Supreme Court, U.S.
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No. 95-5

IN THE

Supreme Court of the United States

October Term, 1995

GERALD MOSS, Ph.D., M.D.,

Petitioner,

against

MARK R. CHASSIN, M.D., as Commissioner of the State of New York Department of Health, STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT, and ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE
NEW YORK STATE SUPREME COURT, APPELLATE DIVISION THIRD DEPARTMENT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES SUPREME COURT

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Questions Presented

1. Whether a physician whose clinical results objectively are assessed and acclaimed as exemplary in his community, and who is recognized nationally and internationally as professionally qualified and experienced in surgical innovation can, consistent with due process under the Federal Constitution, be deprived of his right to practice medicine through disciplinary procedures (i) conducted by reviewers not qualified to judge surgical innovation and (ii) involving participants with an acknowledged bias?

2. Whether state hearing procedures which prevent consideration of the length of delay between alleged events charged and notice of disciplinary hearing (and the prejudice caused by such delay) is contrary to Petitioner's right to due process under the Federal Constitution?

3. Whether pursuant to the right to due process under the Federal Constitution a physician subject to a hearing accusing him of professional misconduct is entitled to a full opportunity to confront and cross examine those testifying against him, by only having expert witnesses testify against him who did not practice on the same medical staff or participate on the same professional committees as the chair of the hearing panel[1]

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[1]All parties to the proceedings below appear in the caption of this case and include Gerald Moss and the respondent Mark R. Chassin, as Commissioner of the State of New York Department of Health; State Board for Professional Medical Conduct; and Administrative Review Board for Professional Medical Conduct. However, it should be noted that Barbara A. DeBuono is the current Commissioner of the State of New Department of Health, succeeding Mark R. Chassin.

4. Whether review by two state agents whose function is related to whether charges should be brought, both of whom admitted to having a personal animus against Petitioner and one of whom actually provided medical treatment in one of the subject medical cases, is contrary to Petitioner's right to due process under the Federal Constitution?

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In the

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MARK R. CHASSIN, M.D., as Commissioner of the State of New York Department of Health, STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT, and ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE NEW YORK STATE SUPREME COURT, APPELLATE DIVISION, THIRD DEPARTMENT

The Petitioner Gerald Moss respectfully prays that a writ of certiorari issue to review the Memorandum and Judgment of the New York State Supreme Court, Appellate Division, Third Department ("Appellate Division") decided and entered in the above-entitled proceeding on November 23, 1994.[2]

Opinions Below

The Order of the New York State Court of Appeals has not been reported. It is reprinted in the appendix hereto, p. 1a, infra.

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[2]Petitioner sought leave to appeal the Appellate Division determination to the New York Court of Appeals. That application was denied by the Court of Appeals by Order dated March 30, 1995 (appendix, p. 1a).

The opinion of the New York State Supreme Court, Appellate Division, Third Judicial Department, has not been reported. It is reprinted in the appendix hereto, p. 3a, infra.

The opinion of the State of New York, Department of Health, Administrative Review Board for Professional Medical Conduct has not been reported. It is reprinted in the appendix hereto, p. 9a, infra.

The opinion of the State of New York, Department of Health, State Board for Professional Medical Conduct Hearing Committee has not been reported. It is reprinted in the appendix hereto, p. 18a, infra.

Jurisdiction

The instant action commenced with the initiation of administrative proceedings against the Petitioner, Gerald Moss ("Dr. Moss"), by the New York State Department of Health's Bureau of Professional Medical Conduct. After an administrative determination and later administrative review, which resulted in revocation of Petitioner's medical license, pursuant to the procedure set forth in Section 230 of New York Public Health Law, Petitioner commenced a proceeding pursuant to Article 78 of New York's Civil Practice Law and Rules. In that proceeding, Petitioner sought judicial review of the administrative review determination in the New York State Supreme Court, Appellate Division, Third Department. By Memorandum and Judgment entered November 23, 1994, the Appellate Division confirmed the administrative determination and dismissed the petition. Petitioner then sought leave to appeal to the New York Court of Appeals. By entry of Order on March 30, 1995, the New York Court of Appeals denied Petitioner's motion, consequently allowing the Appellate Division determination to stand.

This Court has jurisdiction to entertain and grant a writ of certiorari pursuant to 28 U.S.C. §1257.

Constitutional and Statutory Provisions Involved

U.S. Constitution, Amendment V. Due Process of Law.

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

U.S. Constitution, Amendment XIV, Section 1. Due Process.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Statement of the Case

A. Instant Action.

Dr. Moss is a physician with a national and international reputation as a surgeon, innovator and an inventor who has been recognized by his profession for his many achievements, both clinical and as a leader in the field.[3] On or about August 7, 1992, Dr. Moss voluntarily made

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[3]See, e.g., Edward C. Salzstein, Leo C. Mercer, Jack B. Peacock and Steve H. Dougherty; Twenty-Four Hour Hospitalization After Cholecystectomy Surgery, Gynecology & Obstetrics 173:367-370, 1991. See also, pp. 9-12, infra.

arrangements to accept service, from the New York State Department of Health, Bureau of Professional Medical Conduct, of a Notice of Hearing and Statement of Charges concerning his practice of medicine. These papers, among other things, noticed a hearing before the Hearing Committee of the State Board for Professional Medical Conduct, the body charged by New York statute to decide medical conduct cases. (See New York Public Health Law §230).

The misconduct alleged in the statement of charges allegedly occurred in 1983, 1984, 1985 and January of 1986. Despite the alleged misconduct occurring as early as 1983, the State Board for Professional Medical Misconduct had delayed meeting with Dr. Moss until March 1989, and it delayed further until August, 1992 to issue a statement of charges.

In the administrative proceedings that ensued, Dr. Moss moved for the allegations against him to be dismissed based on provisions of the New York State Administrative Procedure Act which mandate that in conjunction with administrative adjudicatory procedures "all parties shall be afforded an opportunity for a hearing within a reasonable time." (State Administrative Procedure Act, Section 301). This motion was denied, on the ground that the hearing procedures of the Department of health do not permit such an issue to be raised at an administrative hearing.[4] (See 10 New York Code, Rules & Regulations, Part 51, et seq.)

During the administrative proceeding, Dr. Moss also requested that the sources of the complaints against him, and the dates of the complaints, be disclosed. Such requests were denied. This information was not disclosed even though it is submitted that some of the patients at issue, or members of their families, provided testimony in the administrative proceeding. It is believed that either the patients at issue or members of their immediate families or extended families, were the source of some or all of the above-referenced complaints, and that due to malpractice suits commenced by said persons, their

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[4]Such an objection was also made at the Pre-Hearing Conference.

credibility was in issue and a vital matter to Dr. Moss' defense and Dr. Moss' right to fully confront and cross examine the witnesses brought against him in the hearing. Also, the timing of the complaints could shed light on the approximately 10 year delay in conducting the hearing.

During the administrative proceeding, Dr. Moss also raised additional fairness issues and due process objections. One of the procedural inequities involved Dr. Maynard Guest, who pursuant to New York Public Health Law §230, held conferences with Dr. Moss in 1989 and 1991 to provide Dr. Moss the statutorily required opportunity to explain the care of the patients at issue. It has been admitted by Dr. Guest that he previously had personal "experience" with Dr. Moss, and that he had a substantial problem with Dr. Moss' treatment of one of his patients. Dr. Guest's patient was not involved in these disciplinary charges but was a patient who, through no fault of Petitioner, had died on the operating table, and Dr. Guest acknowledged the negative predisposition this event caused with regard to his view of Petitioner as a surgeon. By his own admission, Dr. Guest was not impartial with respect to his convening of the interview process for Dr. Moss.

To make matters worse, Dr. Guest had also stated that because he is not a surgeon, he selected a surgeon to assist him in the Section 230 interview process, who was to provide an evaluation of Dr. Moss' surgical care. Dr. Guest selected Dr. Harvey Bernard to participate in this review of Dr. Moss' care, even though Dr. Bernard was known by Dr. Guest to have had a preconceived negative impression of the Petitioner and a long history of hostile behavior towards him. Although Petitioner was prevented from testifying in full on the matter, in Dr. Guest's own words, Dr. Bernard had "crossed swords" with Dr. Moss in the past, thus establishing that Dr. Bernard was also not impartial to Dr. Moss, but prejudiced. Furthermore, Dr. Bernard participated in the Section 230 interview process in the cases at issue, despite the fact that Dr. Bernard had actually been involved in the care of one of the patients at issue, after that patient was cared for by Dr. Moss.

Besides the flawed interview process, which caused a hearing procedure to be initiated, additional due process violations were encountered, resulting in additional objections on the part of Dr. Moss. One such constitutional impropriety concerned the relationship between Dr. Myers, Chairman of the Hearing Committee, and Dr. Eberle, the Department of Health's expert witness.

In this instance, Hearing Committee Chairman Myers stated that he knew Dr. Eberle, having practiced with him on the same medical staff at the same institution in Syracuse, New York. Since both physicians belonged to the same medical staff, it was clear that a relationship existed giving rise to preconceived opinion of the State's medical expert, and further, that it would be essentially impossible for Dr. Moss' counsel to establish the nature of the possible impact of this relationship through cross examination of Dr. Eberle. Dr. Eberle had also served with Dr. Myers on at least one professional committee, and this also lent weight to a legitimate concern as to Dr. Myers' undisclosed preconceived opinion as to Dr. Eberle's expertise. Dr. Myers even stated that he had the predisposition that Dr. Eberle is a competent physician.

Dr. Moss objected to the use of Dr. Eberle as a witness and asserted that the expert witness not be a person whose testimony would be weighed either more or less favorably, based upon the members of the panel having prior knowledge or interaction with such witness. The relationship between Dr. Eberle and Hearing Committee Chairman Myers created a situation where Dr. Myers was influenced in his review of Dr. Eberle's medical testimony, without providing Dr. Moss knowledge of the facts influencing the weight or impact of that testimony, or an adequate opportunity for cross-examination with respect to the same. Dr. Moss' objection requesting disqualification of Dr. Eberle was denied. Due to such circumstances, Dr. Moss was then forced to move for disqualification of Dr. Myers, the Chairman of the Hearing Committee. Such request was denied by a written determination of the Administrative Officer who presided over the proceeding.

Incredibly, the problems of the Department with its expert witness also related to the interview process. It should also be noted that with respect to the Department of Health's obtainment of an expert witness, after the March, 1989 conference with Dr. Moss, Dr. Guest stated that Dr. Bernard (who was acknowledged to have been prejudiced against Dr. Moss) was actively seeking, but could not find, a surgeon who would provide adverse testimony with respect to the patients at issue in the proceeding herein. Over two and one-half years later (October 1991), the proceedings were resumed immediately, apparently after the Department of Health was able to find a cooperative expert in Dr. Eberle.

The proceedings were then resumed, more than 31 months later by means of a second Section 230 conference with Drs. Guest and Bernard. Dr. Guest testified that Dr. Moss was called a second time to review patients initially scheduled, but not discussed during the first meeting. However, only two of the patient cases initially scheduled to be discussed at the first conference had not been discussed at that first conference. These complaints were not subsequently discussed at the second interview, and ultimately were dropped. Therefore, contrary to Dr. Guest's assertion, the second interview was merely a new effort, by Dr. Bernard, to reopen professional complaints that had apparently been dormant due to the absence of expert criticism.

By decision and order dated March 24, 1993, the Hearing Committee of the State Board for Professional Medical Conduct ordered that the medical license of Dr. Moss be limited to the area and type of practice of consultation.

In response to the determination and order of the Hearing Committee, Dr. Moss sought review of the State Board for Professional Medical Conduct Hearing Committee's determination by the Administrative Review Board for Professional Medical Conduct, raising issues with respect to the fairness and due process issues detailed in the

current request for review.[5] The Department of Health also requested review, requesting that Dr. Moss' license be entirely revoked.

The Administrative Review Board ("Review Board") issued a Determination and Order (ARB No. 93-18), among other things, overruling the Hearing Committee's penalty limiting Dr. Moss' license to consultation and ruling that his license to practice medicine in the State of New York be revoked. In part, the Review Board increased the penalty against Dr. Moss because it had questions as to how the Hearing Committee's penalty limiting Dr. Moss' practice to consultation could be enforced.

Dr. Moss then timely commenced an Article 78 proceeding in the Appellate Division of the State Supreme Court, challenging the above determinations on due process and other grounds. That proceeding resulted in a confirmation of Dr. Moss' license revocation, the Appellate Division finding no basis to overturn the revocation (p. 3a).

Thereafter, Petitioner timely moved for leave to appeal to the New York, Court of Appeals for review of the Appellate Division determination. That motion was denied by Order of the Court of Appeals on March 30, 1995, thereby allowing the Appellate Division determination to remain in effect (p. 1a).

B. Parallel Action.

In response to the involvement of the Dr. Bernard in the prosecution of Dr. Moss, Dr. Moss initiated a civil rights action in Federal Court pursuant to 28 USC Sections 1331, 1343 and 42 USC Section 1983, alleging that Dr. Bernard, a physician acting as a supposedly unbiased "interviewer" pursuant to New York Public Health Law, Section 230(10)(a)(iii), maliciously interjected himself into the professional disciplinary process against Dr. Moss for the sole purpose of carrying out a personal vendetta against him.

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[5]The Administrative Review Board is the body empowered by Public Health Law §230 and §230-c to review Hearing Committee decisions.

The complaint alleged that Dr. Bernard is a physician who had a well-recognized, long-standing animosity toward Dr. Moss and who carried a grudge and vendetta against Dr. Moss. Dr. Bernard's vindictiveness and bias made him ill-suited to evaluate Dr. Moss' work; yet that is precisely the role into which he interjected himself. Dr. Moss claims that he did so for the sole and malicious purpose of carrying out his vendetta against him.

The complaint further alleged that Dr. Bernard influenced the bringing of charges despite his awareness that the practices of Dr. Moss, which were at issue, had received exemplary clinical results and were editorially lauded as among the best achieved in the Country and that other surgeons independently reported favorable results when duplicating Dr. Moss' techniques. The complaint notes that an award winning video, which was featured at the annual American College of Surgeons meeting, featured Dr. Moss and his innovative surgical techniques. A published commentary by Dr. Gordon Vineyard, a Harvard Surgery Professor, which accompanied the video stated:

> "Dr. Moss' record is truly remarkable. He has now discharged 240 patients the day after surgery and the last 158 of these cases were consecutive. The results have been duplicated, at least partially, by others, and I have visited with Dr. Moss, watched his surgery and interviewed his patients before and after surgery. I was profoundly impressed.
>
> I believe we owe Dr. Moss a great debt. He has run the 4 minute mile. He has been an important innovator in advancing our ability to allow our patients to recover quickly and happily from major abdominal surgery. Since 1980, only one of Dr. Moss' 253 cholecystectomy patients has had a post operative surgical infection. This rate (<0.4%) is a full order of magnitude lower than reported in the literature." (Emphasis Added).

The complaint also alleged that Dr. Nahrwold, Surgery Chairman at Northwestern University, also provided comment with respect to Dr. Moss, stating:

> "Dr. Moss has confirmed that patients can be discharged within 24 hours of elective cholecystectomy without a high incidence of complications. (emphasis added). Especially noteworthy are the methods he used to reduce the pain and suffering usually associated with a major operative procedure."

In addition, the October 1986 issue of the Journal of the American Medical Association was devoted to reviewing the year's major advances. Dr. Moss' surgical regimen was singled out in that publication by Dr. Arthur Baue, Chairman of the Yale University Surgery Department. It is believed that Dr. Bernard was aware of these publications, and the 30-40 major medical center and community hospital teaching invitations Dr. Moss received annually.

There can be no reasonable dispute that Dr. Gerald Moss is nationally and internationally recognized and respected as a surgical innovator, challenging and discrediting established dogma.[6] For over 30 years, he has been reporting on his technique to immediately feed and sooner discharge surgical patients.[7] His patients' clinical outcomes have been widely and regularly reported since 1963 in the surgical literature, and he has been invited for presentations at professional

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[6]Moss G, Staunton C: Blood flow, needle size and hemolysis; Examining an old wives' tale. New England Journal of Medicine 2823:967, 1970.

[7]Moss G: Nitrogen equilibrium in the early postoperative period. Surgical Forum 14:67-70, 1963.

meetings and at major medical centers.[8] These results have been closely scrutinized and editorially lauded.[9]

Empire Blue Cross/Blue Shield of New York independently assessed Dr. Moss as having the best clinical results in it service area of New York State (which included Albany) using objective "outcome criteria" in 1983.[10] They sponsored a confirming prospective study of his clinical practice conducted by the Visiting Nurses Association of Albany. They presented and published their corroborating reports, which were instrumental in inducing other surgeons to emulate Dr.

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[8]Moss G: Postoperative decompression and feeding. Surgery, Gynecology & Obstetrics 122;550-4, 1966. (Currently renamed Journal of the American College of Surgeons);

Moss G: Postoperative ileus is an avoidable complication. (editorial) Surgery, Gynecology & Obstetrics 148:81-82, 1979 (Currently renamed Journal of the American College of Surgeons);

Moss G, Nassif AC: Preserved postoperative GI function and full enteral nutrition. Surgical Rounds 9:66-85, 1986;

Moss G: Gut function after severe trauma. In: Symposium on Management of Trauma, Columbia University, College of Physicians and Surgeons, Harlem Hospital Center, New York: 1987.

[9]Moss G: Discharge within 24 hours of elective cholecystectomy: The first 100 patients. Archives of Surgery 121:1159-61, 1986. (Editorial commentary by David L. Nahrwold, Professor & Chairman, Surgery Department Northwestern University).

[10]Regal ME, Lichtig LK: Immediate and sustained nutrition leads to safe early discharge after cholecystectomy (abstract). Journal of the American College of Nutrition 2:319, 1983. (Visiting Nurse Association of Albany and Empire BC/BS of NE NY);

Moss G, Regal ME, Lichtig L: Reducing postoperative pain, narcotics and length of hospitalization. Surgery 90:206-10, 1986

Moss in reducing patient postoperative incapacity, length of hospitalization, and complications.[11]"

Following the filing and service of the complaint in that action, Dr. Bernard moved pursuant to FRCP 12(b)(6) to dismiss the complaint for failure to state a claim upon which relief may be granted. The Court granted Dr. Bernard's motion and dismissed the complaint. This dismissal occurred prior to the State Court final determination.

The Petitioner duly appealed in that case to the Second Circuit Court of Appeals. While the appeal in the Second Circuit was under consideration, the Appellate Division of the New York State Supreme Court affirmed the license revocation, and in doing so, rejected the arguments Petitioner had raised in that case based on Dr. Bernard's improper conduct on the ground that in the absence of proof that such conduct tainted the entire administrative process, there was no such basis to vacate the administrative discipline. While the case against Dr. Bernard was sub judice in the Second Circuit, a request for relief to appeal the State Court license revocation was pending in the New York State Court of Appeals. That motion requesting leave to appeal was ultimately denied. However, before that denial, the Second Circuit affirmed the District Court decision, without prejudice in the event the license revocation was reversed.

By means of a separate Petition for a Writ of Certiorari, filed with this Court on May 23, 1995, Dr. Moss has sought review of the determination involving Dr. Bernard. While it is submitted that any determination regarding the impropriety of Dr. Bernard's actions is independent from the instant action, the Second Circuit has held otherwise, consequently making Dr. Moss' constitutional rights contingent upon the outcome of the instant action.

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[11]Fitzgerald TE, Page DW: Esophagogastric decompression and immediate enteral feeding following colon surgery (abstract). Journal of the American College of Nutrition 3:280, 1984 (Tufts University).

REASONS FOR GRANTING THE WRIT

POINT I

State Law Prevents Consideration Of Undue Delay In The Administrative Hearing Process

The Appellate Division rejected the Petitioner's claim that he was subjected to unreasonable delay in connection with the hearing process. In this instance, the delay of nearly nine years in some of the cases virtually speaks for itself. However, the Court held that there was no basis to overturn the hearing panel determination despite this delay, citing Matter of Cortlandt Nursing Home v. Axelrod (66 NY2d 169, 180, cert. denied 476 US 1115); Matter of Matala v. Board of Regents of Univ. of State of New York (183 AD2d 953); and Matter of Rojas v. Sobol (167 AD2d 707, lv. denied, 77 NY2d 806). In view of the record in this case, it is respectfully submitted that the Appellate Division has established an erroneous standard for evaluating the prejudice which must be proven to establish a denial of due process, and has applied that standard in light of a Department of Health regulation that prevents any effective review on the issue of delay.[12]

Incredibly, under Department of Health regulations the delay of nearly 10 years in this case could not even be considered, much less be deemed dispositive in the administrative proceeding under review. This is because the Department regulations preclude consideration of any delay except the delay between the notice of hearing and the first hearing date, which in this case was insignificant (see 10 NYCRR 51.11[10]).

The State's purported inability to consider the unreasonable delay between the alleged misconduct and the issuance of charges or the first hearing date, denies Dr. Moss review as to whether or not adequate

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[12]Petitioner also contends that the Appellate Division's ruling is inconsistent with the ruling in Cortlandt.

standards of due process existed. "The fundamental requisite of due process of law is the opportunity to be heard." Grannis v. Ordean, 234 US 385, 394. Included within that constitutional principle is the requirement that the hearing be held "at a meaningful time and in a meaningful manner." Armstrong v. Manzo, 380 US 545, 552. In order for the time and manner to be meaningful, the hearing must be held at a time sufficiently close to the acts of alleged misconduct, whereby the issues can be sufficiently adjudicated without the occurance of faded memories and long lost documents.

The Department of Health's regulation has never been the subject of judicial review in the context of a case such as this. The regulation provides in pertinent part:

> Claims that an administrative hearing has been unreasonably delayed shall be raised only pursuant to this section and claims of unreasonable delay not permitted by this section shall not be entertained in a hearing.
>
> (i) In reviewing a claim of unreasonable delay, the hearing officer shall first calculate the time period that has elapsed between the date the hearing was requested or noticed, whichever is earlier, and the first day of hearing (the "time period"). For purposes of this section, the time period for cases brought pursuant to Public Health Law, section 2803-d or 230, or Subpart 60-1 of this Title, shall be from the date the hearing was noticed to the first day of hearing.
>
> (ii) If the time period is one year or less, the claim of unreasonable delay shall be denied.

(10 NYCRR §51.11[10]) (emphasis added).

This myopic review of delay, applying only to the period between the date the hearing is noticed and the first day of the hearing, conspicuously disregards the far more relevant time period between the date of the alleged misconduct and the first day of the hearing, in this case nearly nine years of delay, which also occurred in the context of alleged bias in the commencement of the interview process.

The regulatory limitation also gives Petitioner no remedy at all in the administrative forum where, as in this case, substantial and critical evidence was unavailable due to lapse of time. Under the Respondent's regulation, the type of delay argument made by Petitioner here--between the patient care and the bringing of charges--is not even to be "entertained" at the hearing. There is no adjudicatory forum in which to raise due process issues caused by excessive delay. It appears that the only practical limit on the delay countenanced by the Respondents' regulation is the lifetime of the physician charged.

The alleged medical misconduct in this case occurred in 1983, 1984, 1985 and January of 1986. The State Board for Professional Medical Conduct delayed until 1992 to issue a Statement of Charges. This case involved five separate and highly complex medical situations. The statute of limitations on any malpractice claim would have long since expired, (See New York CPLR 214-a), which surely demonstrates at the very least New York's public policy respecting such egregious delay. Yet Petitioner was forced to defend in an administrative forum with the unfair disadvantage of lost evidence, absent and deceased witnesses and the failure of witness' recollection of crucial events.

The nature of the private interest compromised by the delay in this case is clearly substantial and critically affected. It is the Petitioner's professional reputation. Even though he is no longer actively practicing, he clearly had an important interest in his ability to proceed, without a cloud on his reputation, with lecturing, research and business ventures dependent upon his reputation and without the debilitating

fear of disciplinary action against his license based upon alleged violations that are six to nine years old.

Moreover, there is clearly actual prejudice to Petitioner in that this delay hindered the uncovering of relevant facts due to the death[13] and resulted in the absence of important witnesses, the absence and illegibility of necessary documents and natural memory loss. This was repeatedly noted in the record. For example, Petitioner was accused of ignoring one patient's complaints of pain, yet the prescription records for that patient which could show pain medication was barely taken were unavailable. Another patient's case involved alleged inattention to that patient the same day he was turned over to the patient's personal doctor, Dr. Gavin, who had treated that patient that day. Unfortunately, Dr. Gavin had a severely faded memory as to what had occurred on the day of the patient's transfer. Also, as is evident from the transcript, some witnesses developed severe inconsistencies in their testimony since testifying in court years earlier. Office records regarding another patient, which could have shed light on whether the patient declined to meet a scheduled appointment, were unavailable.

There are many other examples in the record. Attached as pages 117a et seq. in the appendix are pages 15-28 of Petitioner's Reply Brief in the Appellate Division, which establishes a detailed factual account of the actual prejudice due to the delay. In view of the limited scope of review in the Appellate Division, in the context of an Article 78 proceeding, and the fact that the type of delay claimed here "shall not

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[13]For example, Dr. Benitez, the pathologist who did the autopsy for one of the patients, had died, and it was impossible to fully examine the question of whether that patient was merely suffering incisional pain, or, as her family claimed, peritonitis before her death. Although the tissue samples showed an absence of peritonitis, the flawed autopsy procedures and the unavailability of Dr. Benitez caused an undue need to rely on the subjective characterizations of that patient's family (who had unsuccessfully sued Petitioner for malpractice) as opposed to unassailable clinical evidence which was no longer available.

be entertained" at the administrative level, Petitioner has been deprived of an effective review on the delay issue, and consequently deprived of a determination as to whether the extent of the delay violated his constitutional right to due process. It is submitted that review is needed in this case to prevent 10 NYCRR 51.11(10) from having this constitutionally unfair impact.

POINT II

Petitioner Was Not Provided A Fully Impartial Hearing Panel

Petitioner's due process rights were also compromised by the composition of the hearing panel and the relationship of the chair of the hearing panel to the State's expert witness. Dr. Moss was entitled to have a hearing panel that witness produced by the Office of Professional Medical Conduct, as due process of law mandates an unbiased and impartial administrative tribunal. Goldberg v. Kelly, 397 U.S. 254, 271. In this instance, Dr. Myers, the Chairman of the Hearing Committee, indicated that he did have knowledge of the State's expert, Dr. Eberle, having practiced with him in Syracuse, New York.

Both physicians were members of the same medical staff, and apparently Dr. Eberle had also served with Dr. Myers on at least one professional committee. An objection was duly made in the administrative proceeding, and in subsequent administrative and judicial review, that Dr. Moss was entitled to have witnesses brought against him who would not have their testimony weighed either more favorably or less favorably based upon prior knowledge of members of the panel. The existence of the relationship between Dr. Eberle and Dr. Myers created a situation where Dr. Myers would be influenced in his review of Dr. Eberle's medical testimony, but there would not be knowledge of the basis of that influence and an adequate opportunity for cross examination.

This created a situation whereby Dr. Moss was denied his right to due process, as the right to confront and cross-examine witnesses applies to administrative proceedings as well. Morrissey v. Brewer, 408 US 471, 489; Willner v. Committee on Character and Fitness, 373 US 96, 105-05. Here, the relationship between Drs. Myers and Eberle denied Dr. Moss of a full opportunity to cross-examine, as is constitutionally required.

The transcript of the underlying proceedings provides a clear indication that Dr. Myers had a predisposition with respect to the credibility of Dr. Eberle's testimony, in that he explicitly testified that he believed Eberle was likely to be a good surgeon (p. 99a et seq.)

The Appellate Division relied on Matter of Warder v. Board of Regents (53 NY2d 186), for the proposition that relationships between the hearing panel chair and the expert witness are not inappropriate unless the Petitioner could show that there was actual bias and that the outcome flowed from it.

The application of the Warder rule to facts of a case such as this results in the extremely inequitable circumstance of the Petitioner being placed in a position of aggressively cross-examining the chair of the hearing panel to determine exactly what connections existed between he and the State's expert witness. This illustrates the distinction between this case and the Warder case, which involved allegedly unfounded allegations of "brainwashing" against the Unification Theological Seminary.

This case is subtly different. What is argued is not bias in its nefarious sense, but rather the difficulty of Petitioner in preparing for a cross examination of the State's witness, without having knowledge of how the expertise of the State's expert witness had been viewed by the chair of the hearing panel during their professional association. Since there is almost no discovery in professional disciplinary proceedings, the impression of the expert witness held by the chair of the hearing panel, especially since they had practiced on the same medical staff, would be a comprehensive impression impossible for

Petitioner to ascertain or evaluate and one which seriously impeded his right to due process.

Balancing such prejudice suffered by Petitioner against the remedy for such a situation illustrates the impropriety of applying the Matter of Warder standard to a case such as this. The connection between physicians practicing on the same medical staff and on the same medical committees is sufficiently close to ensure that there will be pre-existing knowledge and opinion, even absent Dr. Myers' acknowledgment that he had a preconceived disposition that Dr. Eberle was likely competent.

Also, in this case, the commencement of the hearing process with admittedly biased interviewers establishes a much higher need to avoid such relationships between the panel and expert witnesses, so as to avoid the Constitutional inequity which occurred in this case--of fundamental impropriety and lack of due process and a reasonable conclusion by the disciplined physician that the entire process is a sham.

POINT III

The Appellate Division Applied An Improper Standard In Determining Whether Due Process Had Been Satisfied.

Within the scheme of providing due process to accused physicians, the statutory provisions of New York's disciplinary process provide:

> In the investigation of cases referred to an investigation committee, the licensee being investigated shall have an opportunity to be interviewed by the Office of Professional Medical Conduct in order to provide an explanation of the issues under investigation. . . . Providing an opportunity for such an interview shall be a condition precedent to the convening of an investigation committee on professional misconduct of the Board for Professional Medical Conduct.

(Public Health Law §230[10][a][iii])

It is fundamental that in order for that statutory provision to allow for the proper exercise of due process, the interviewers must be fully impartial and open to Petitioner's fair explanation, as the codified state provisions providing due process were designed to provide a neutral medical expert to evaluate potential charges of professional misconduct before they are brought. This legislative design is subject to abuse when, as here, the supposedly neutral medical expert is not dispassionate, but rather acts to carry out a vendetta and undermine the prophylactic purpose of his position.

Petitioner in this case was interviewed by Dr. Maynard Guest, who admitted that he previously had experience with Dr. Moss, and that he had a substantial problem with Dr. Moss' treatment of one of Dr. Guest's own patients who had died on the operating table. Accordingly, by his own admission, Dr. Guest could not have been impartial with respect to his convening of the interview for Dr. Moss.

Dr. Guest described this case, as follows:

> A I never confronted Dr. Moss about it, but we had shared a patient a long time ago, a man who had obstructive jaundice, and -- shall I continue with this? At any rate, the patient, I felt, had surgical jaundice and felt that he should have a laparotomy immediately. There were complicating factors, there was a young physician who had just finished a residency in radiology, wanted the patient to be in Albany Med, the patient was hospitalized at St. Peter's, kept throwing up roadblocks. I don't know whether he got to Dr. Moss or not, but at any rate, the surgery was delayed, I felt, inordinately. The patient finally had severe jaundice, bilirubin of close to 30, had elevated prothrombin time. The surgery was finally done. Patient also had bowel peritonitis from transcutaneous cholangiography which had been done by a radiologist.

> At any rate, patient died on the table I don't know exactly what transpired on the table but I feel -- I was unhappy at the time, although I never talked to Dr. Moss about this case, but that's the first time I have any feelings about Dr. Moss's practices.

* * *

In addition, Dr. Guest testified that because he is not a surgeon, he selected a surgeon who was to provide an evaluation of Dr. Moss' surgical care. Dr. Guest apparently selected Dr. Harvey Bernard to review Dr. Moss' care, even though Dr. Bernard was known by Dr. Guest to have "crossed swords" with Dr. Moss in the past, thus indicating that Mr. Bernard also was not impartial and prejudiced.

Dr. Guest described Dr. Bernard's involvement as follows:

Q Would you see Dr. Bernard hostile to Dr. Moss at all?

A At the time I didn't think he was; probably Dr. Moss did, but I didn't think he was. I know that Dr. Moss and Dr. Bernard have crossed swords in the past.

Q Really?

A Well, going way back when Dr. Moss was a resident, I understand. This is rumor, things which I just have heard.

Q So, Dr. Bernard was involved with Dr. Moss in the past and, to use your phrase, had crossed swords with him in the past and then he was brought in by the Board for Professional Medical Conduct to be involved in the evaluation of these cases for the determination of whether to present time to an expert to decide if charges were going to be brought?

A Because he's a surgeon and I'm an internist.

Q I understand.

A I had to have a surgeon, in fairness to Dr. Moss.

Q And Dr. Bernard was the person who was brought in in fairness to Dr. Moss?

A Well, when you're looking at a case -- when I'm looking at a case, if my twin brother, if I had a twin brother, if he committed medical misconduct, either negligence or incompetence, the facts are the facts, no matter whether I have favorable feelings toward him or not. I have nothing personally against Dr. Moss and I don't think Dr. Bernard -- if you just take the material that you review and you leave your emotional feelings out of it entirely when do we these cases, otherwise we're not doing our job.

Q Well, would you agree that as a matter of practice, the persons or physicians involved in evaluating another doctor's conduct should not -- should at the very least not be people who have crossed swords with the particular doctor in the past?

A I don't think that matters. I can tell you this, while we're on this: There are two physicians in town who, as far as I'm concerned, they have done me dirt. I've seen complaints come in against them and I've dismissed them, just as I think Dr. Bernard, if he were in my position, would not let -- there is no way that we can make our personal feelings play a role in our decisions about these cases, there's no way; and if I wanted to --

Q You mean there is no possibility that a person involved in Dr. Bernard's position would not be wholly impartial?

A Dr. Bernard is looking at these, it could have been Dr. Moss, could have been any other surgeon. The facts are the

facts, there they are. You can't insinuate your emotions into decisions about whether or not there have been substandard practices, you can't do it.

Q Now, Dr. Bernard was the surgeon and he was the one who was really involved in evaluating the surgical practice, is that right?

A Well, that's right.

* * *

Pursuant to subdivision 10 of Section 230 of the Public Health Law, and the due process concept of fundamental fairness, Dr. Moss was entitled to, upon the investigation of the cases involved herein, consultation by a medical expert that had no preconceived views on his medical practice. In addition, Dr. Bernard participated in the evaluation of Dr. Moss' care in these cases despite the fact that in one of the cases, Dr. Bernard had actually been involved in the care of the patient.

Dr. Bernard's advance knowledge of the facts, involving at least the patient with which he was involved, and his pre-judgment of certain facts and bias against Dr. Moss, justifies the setting aside of the Hearing Committee's decision. The right to an impartial adjudication is a basic element of due process. This aspect of due process applies equally in an administrative setting as it does a judicial forum (see, Schweiker v. McClure, 456 US 188; see also, Gibson v. Berryhill, 411 US 579).

Accordingly, individuals are constitutionally entitled to unprejudiced administrative adjudications; anything less serving as a basis for annulling a determination rendered absent such constitutional protections (see, Withrow v. Larkin, 421 US 35, 46-47; Gibson v. Berryhill, 411 US 564). If the apparent providers of due process cannot approach a proceeding with an open mind, without bias and without prejudgment of issues, the required legal process becomes

illusory, and the hearing a mere sham. Not only is a biased decision maker constitutionally unacceptable, but it is contrary to "our system of law [which] has always endeavored to prevent the probability of unfairness." In the Matter of Murchinson, 349 US 133, 136.

In ruling on this issue, the Appellate Division stated that there must be a factual demonstration supporting the allegation of bias and "proof that the outcome flowed from it" (Appendix, p. 5a). However, in ruling that there must be direct proof that the prejudice of the interviewers impacted on the ultimate outcome of the case, the Court below effectively set a standard that there must be an admission by the allegedly prejudicial participants in the hearing process, to the effect that prejudice actually impacted on their recommendation. What is more significant is that the Appellate Division's ruling required that the Petitioner show nothing less than the actual impact of the prejudice on the subsequent decision. It is respectfully submitted that this holding effectively disregards fundamental principles of due process absent an absolute confession on the part of the biased individual with regard not only to his bias, but the full extent of his involvement in the proceedings; aspects which are not the subject of discovery.

It is respectfully submitted that if the view of the Appellate Division were to prevail, it is the equivalent of holding that no amount of prejudice on the part of the interview personnel, no matter how outrageous, can ever result in an impact on the final disciplinary process and the constitutional due process rights of the accused. This is because the subsequently convened hearing committee always will be arguably distinct from the prejudicial interview panel, and the Petitioner will be unable to prove otherwise.

If the interview process is to properly provide the necessary degree of due process protection, and serve as a protective gate to the disciplinary process, it makes no sense to require the onerous standard on bias invoked by the Appellate Division in this case, which from either a practical legal standpoint is essentially impossible.

CONCLUSION

The writ requested in the instant petition should be issued.

Dated: June 26, 1995

GLEASON, DUNN, WALSH & O'SHEA
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Attorneys for Petitioner Gerald Moss

Counsel of Record:
BRENDAN C. O'SHEA

Order of the State of New York, Court of Appeals, dated March 30, 1995.

STATE OF NEW YORK

COURT OF APPEALS

At a session of the Court, held at Court of Appeals Hall in the City of Albany on the thirty day of March 1995

Present, Hon. Judith S. Kaye, Chief Judge, presiding.

3-10 Mo. No. 56

In the Matter of Gerald Moss,

Appellant,

v.

Mark R. Chassin, as Commissioner of the State of New York Department of Health, *et al.*,

Respondents.

A motion for leave to appeal to the Court of Appeals in the above cause having heretofore been made upon the part of the appellant herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

ORDERED, that the said motion be and the same hereby is denied.

Judge Levine took no part.

s/ DONALD M. SHERAW
Donald M. Sheraw
Clerk of the Court

Memorandum and Judgment of the New York State Supreme Court, Appellate Division, Third Department, decided November 23, 1994.

SUPREME COURT - APPELLATE DIVISION
THIRD JUDICIAL DEPARTMENT

Decided and Entered: November 23, 1994

IN THE MATTER

OF

GERALD MOSS,

Petitioner,

v.

MARY R. CHASSIN, as Commissioner of the State of New York Department of Health, *et al.*,

Respondents.

69162
MEMORANDUM AND JUDGMENT

Calendar Date: October 12, 1994
Before: Mikoll, J.P., Mercure, Crew III, White and Yesawich Jr., JJ.

Gleason, Dunn, Walsh & O'Shea (Thomas F. Gleason of counsel), Albany, for petitioner.

G. Oliver Koppell, Attorney-General (Mark G. Peters of counsel), New York City, for respondents.

White, J.

Proceeding pursuant to CPLR article 78 (initiated in this court pursuant to Public Health Law § 230-c [5]) to review a determination of the Administrative Review Board for Professional Medical Conduct which revoked petitioner's license to practice medicine in New York.

In March 1989 and in October 1991, petitioner, a licensed physician who is internationally recognized as an expert in the field of enteral nutrition, was interviewed by the Office of Professional Medical Conduct (hereinafter OPMC) regarding its investigation of petitioner's treatment of five patients (hereinafter patients A, B, C, D and E) between 1983 and 1986. Thereafter, in August 1992, OPMC filed 10 specifications of professional misconduct against petitioner. Following a hearing, a Hearing Committee of the State Board of Professional Medical Conduct (hereinafter the Hearing Committee) found that petitioner was guilty of gross negligence in regard to his treatment of patients A, C and D; practicing medicine with negligence on more than one occasion with respect to his treatment of patients A, C, and D; and failure to maintain adequate medical records relative to patients A, B, C and E. Based on these findings, the Hearing Committee determined that petitioner's license to practice medicine should be limited to consultation to the exclusion of all other types of medical practice. OPMC and petitioner appealed to the Administrative Review Board for Professional Medical Conduct (hereinafter the Review Board). It sustained the Hearing Committee's findings but overruled the penalty it had levied, imposing instead the

penalty of revocation of petitioner's license. Petitioner then commenced this CPLR article 78 proceeding.

As part of his challenge to the Review Board's determination, petitioner has raised several arguments under the rubric of denial of due process. The first is that his due process rights were violated by OPMC's delaying until 1992 to issue the charges against him. This argument is unavailing unless petitioner can show that he sustained actual prejudice as a result of the delay (*see, Matter of Cortlandt Nursing Home v Axelrod,* 66 NY2d 169, 180, *cert denied* 476 US 1115; *Matter of Matala v Board of Regents of Univ. of State of N.Y.,* 183 AD2d 953; *Matter of Rojas v Sobol,* 167 AD2d 707, *lv denied* 77 NY2d 806). Petitioner claims that he delay had an adverse impact upon him since the pathologist who performed the autopsy on patient A died before the hearing and certain records relating to patients B and D had been lost. We disagree since the pathologist's testimony regarding the cause of patient A's death would have had little relevance to the charge that petitioner had inappropriately discharged her from the hospital following her operation and that he had inadequately evaluated and treated her thereafter (*compare, Matter of Sharma v Sobol,* 188 AD2d 833). Likewise the information purportedly contained in he lost documents would have had a minimal impact on the hearing. Thus, we find that petitioner has not sustained this argument.

Petitioner's next argument is that he was denied a fair hearing because the doctors who conducted the interview, afforded him under Public Health Law § 230 (10) (a) (iii), were biased. He further argues that the Hearing Committee was biased because its Chair was acquainted with OPMC's expert witness. Merely alleging bias is not enough to set aside an administrative determination (*see, Matter of Jeremias v Sander,* 177 AD2d 488). Instead, there must be a factual demonstration supporting the allegation and proof that the outcome flowed from it (*see, Matter of Hughes v Suffolk County Dept. of Civ. Serv.,* 74 NY2d

833, 834; *Matter of Warder v Board of Regents of Univ. of State of N.Y.*, 53 NY2d 186, 197).

Here, there is no proof that the doctors' alleged bias infected the Hearing Committee or the Review Board, thereby disabling those bodies from hearing and deciding this matter on the basis of the evidence presented at the hearing (*see, B.A.M. Brokerage Corp. v State of New York*, 718 F Supp 1195). Nor did petitioner establish that the integrity of the Hearing Committee was compromised by its Chair's acquaintance with OPMC's expert witness since he did not come forward with proof overcoming the presumption of honesty and integrity which is accorded to members of administrative bodies (*see, Matter of Rine v City of Sherrill*, 195 AD2d 961, *lv denied* 82 NY2d 660; *Matter of Amarnick v Sobol*, 185 AD2d 485; *Matter of Reisner v Board of Regents of Univ. of State of N.Y.*, 142 AD2d 22). For those reasons, we find that petitioner was not denied due process on the ground that he was denied an impartial hearing.

Petitioner urges us to apply the holding of *Matter of McBarnette v Sobol* (83 NY2d 333) to this case in light of the denial of his request to examine OPMC's files so he could ascertain the first date upon which it had considered charges against him. We decline to do so since the record discloses that petitioner was not seeking the requested information for the purpose of cross-examining complainants who had testified at the hearing, but rather was seeking to utilize the information to bolster his claim of excessive delay (*see, id.*, at 341). Moreover, we have held that *Matter of McBarnette v Sobol (supra)* is not to be applied retroactively except possibly in certain limited circumstances not present here (*see, Matter of Finelli v Chassin*, ___ AD2d ___, 614 NYS2d 634).

Aside from his due arguments, petitioner contends that the Review Board's determination is not supported by substantial evidence. Prefatorily, we note that the proper standard of review here is whether the determination was arbitrary and capricious,

affected by an error of law or an abuse of discretion (*see, Matter of Finelli v Chassin, supra; Matter of Rudell v Commissioner of Health of State of N.Y.*, 194 AD2d 48, 50, *lv denied* 83 NY2d 754). Under this test, the inquiry is whether the administrative determination has a rational basis that is supported by fact (*see, Matter of Pell v Board of Educ.*, 34 NY2d 222, 231). In making this inquiry, we do not resolve credibility issues or weigh the testimony of the expert witnesses, for these issues are solely within the province of the administrative factfinder (*see, Matter of Santasiero v Sobol,* AD2d 835, *lv denied* 83 NY2d 754; *Matter of Briggs v Board of Regents of Univ. of State of N.Y.*, 188 AD2d 836. *lv denied* 81 NY2d 708).

Applying these principles here, we find there is ample evidence supporting the Review Board's findings that petitioner inappropriately discharged patients A, C and D and inadequately treated and evaluated patients A and C. Its finding that petitioner maintained inadequate medical records with regard to patients A, B, C and E also has factual support. Hence, we conclude that the Review Board's determination of guilt is not arbitrary and capricious.

The final issue raised by petitioner is that the penalty of revocation was unfairly imposed because the Hearing Committee refused to allow full testimony regarding his accomplishments and studies on surgical innovation. We reject this contention for the record discloses that petitioner was permitted to adduce his academic credentials and his 38-page curriculum vitae. In any event, petitioner's emphasis on his accomplishments overlooks the fact that a physician's foremost obligation is to his or her patients. Thus, when a physician fails in this obligation to the extent petitioner did, we cannot say that the penalty of revocation is shocking to one's sense of fairness (*see, Matter of Santasiero v Sobol, supra; Matter of Golan v Sobol,* 195 AD2d 634, *lv denied* 82 NY2d 661).

Accordingly, for the foregoing reasons, we shall confirm the determination.

Mikoll, J.P., Mercure, Crew III and Yesawich Jr., JJ., concur.

ADJUDGED that the determination is confirmed, without costs, and petition dismissed.

ENTER:

/s/Michael J. Novack
Michael J. Novack
Clerk of the Court

New York State Department of Health Administrative Review Board for Professional Medical Conduct Determination and Order, executed in July and August, 1993.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

ADMINISTRATIVE
REVIEW BOARD
DETERMINATION
AND ORDER
ARB NO. 93-18

The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D. and WILLIAM A. STEWART, M.D. held deliberations on June 22, 1993, at 5 Penn Plaza in New York, New York,[1] to review the Professional Medical Conduct Hearing Committee's (Committee) April 2, 1993

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[1]Dr. Stewart was not present in New York City for deliberations, but participated by telephone.

Determination finding Dr. Gerald Moss guilty of professional misconduct and limiting his license to practice medicine in the State of New York. Both the Office of Professional Medical Conduct (OPMC) and Dr. Moss requested the review through Notices which the Review Board received on April 14, 1993. James F. Horan served as Administrative Officer to the Review Board. Kevin Donovan, Esq. submitted a brief for OPMC on May 17, 1993 and a response brief on May 26, 1993. Thomas Gleason, Esq. submitted a brief for Dr. Moss on May 17, 1993 and a response brief on May 24, 1993.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230 (10) (i), §230-c (1) and §230-c (4) (b) provide that the Review Board shall review:

> whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
>
> whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c (4) (b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c (4) (c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct charged the Respondent, a surgeon, with gross negligence, negligence on

more than one occasion and failing to maintain adequate records arising from the Respondent's care of five patients, A through E.

The Hearing Committee found the Respondent guilty of practicing with gross negligence arising from his care provided to Patients A, C and D; with practicing with negligence on more than one occasion in treating Patients A, C and D; and with failing to maintain adequate medical records for Patients A, B, C and E.

The Hearing Committee concluded that the Respondent placed Patients A, C and D at substantial risk due to the inappropriate hospital discharge of Patients A and D, and due to the post-discharge evaluation and treatment of Patients A and C. The Committee concluded further that the Respondent's medical records did not meet the mandated requirement to provide objectively meaningful information.

The Committee concluded that they held grave misgivings about the Respondent's continuing to practice surgery. The Committee determined that the Respondent's license to practice medicine should be limited to consultation to the exclusion of all other types of medical practice.

REQUESTS FOR REVIEW

The Office of Professional Medical Conduct has asked that he Review Board modify the Hearing Committee's Determination and Penalty. OPMC asks that the Review Board overrule the Hearing Committee's Determination that the Respondent was not guilty of negligence and gross negligence in treating Patient B, because that Determination is inconsistent with the Committee's findings and conclusions. OPMC also argues that the Hearing Committee's Penalty is inappropriate due to the Hearing Committee's findings that the Respondent was guilty of

gross negligence and negligence on more than one occasion. OPMC asks that the Respondent's license be revoked.

The Respondent argues that the Hearing Committee's Determination that the Respondent was guilty of gross negligence and negligence on more than one occasion in treating Patients A, C and D, and of failure to maintain adequate records for Patients A, B, C and E are not consistent with the Hearing Committee's findings and conclusions. The Respondent also argues that the Committee's Penalty is inappropriate for several reasons which the Respondent's brief discusses at pages 2-10. As one of these grounds, the Respondent argues that it was improper for the Committee to use their assessment of the Respondent personally in making a determination as to the proper penalty to impose in this case.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was guilty of gross negligence and negligence on more than one occasion in treating Patient A, C and D, and was guilty of failing to maintain adequate records from the treatment of Patient's A, B, C and E. The Review Board sustains the Hearing Committee's Determination that the Respondent was not guilty of Negligence and gross negligence in the treatment of Patient B. The Committee's Determination is consistent with the findings of facts and conclusions and is supported by the evidence from the hearing.

The Review Board votes to overrule the limited license penalty which the Hearing Committee imposed, because the penalty is not appropriate and because the penalty is inconsistent with the Committee's findings and conclusions that the Respondent was guilty of gross negligence and negligence on more than

one occasion in treating Patients A, C and D in this case. The Review Board believes that the appropriate penalty, in view of the Respondent's gross negligence and negligence on more than one occasion, is to revoke the Respondent's license to practice medicine in New York State.

The Review Board questions how the penalty limiting the Respondent to providing consultations can be enforced. The Hearing Committee did not provide any definition of consultation in their Determination. Does consultation mean that there will always be a treating physician between the Respondent and any patient? In the case of a young Physician who seeks a consultation with the Respondent, would the Respondent actually be making the decisions concerning the care of the patient?

The Review Board concludes, based on the Hearing Committee's findings and conclusions concerning the Respondent's multiple and egregious acts of negligence, that the Respondent should no longer be involved in patient care. The Hearing Committee stated that they had grave misgivings about the continuation of the Respondent's surgical practice. The Review Board believes that those misgivings should apply to surgical consultations by the Respondent as well as the actual performance of surgery, since the Respondent's gross and repeated acts of negligence involved the inappropriate decision to discharge Patients A and D from the hospital and the post discharge evaluations of Patients A and C.

The Respondent faults the Hearing Committee for basing their determination in the Respondent's case, in part, on the Committee's assessment of the Respondent personally. The Review finds nothing inappropriate in the Committee's using a personal assessment of the Respondent in reaching a determination. Any finder of fact will assess a witnesses' demeanor and responsiveness to questions in determining whether a witness is credible. Further, in OPMC hearings, a Hearing Committee

which sustains charges of gross and multiple acts of negligence against a physician must determine whether that physician is fit to continue practicing in New York State and whether there are any steps such as retraining, re-education or monitoring, which would allow the physician to continue practicing, without endangering the public health. An assessment of a Respondent, based on the Respondent's hearing testimony will assist a Hearing Committee in determining whether the Respondent would be a candidate for retraining or would cooperate with a practice monitor.

In this case, the Hearing Committee's did not find that the Respondent would benefit from retraining or re-education. The Committee's conclusions about the Respondent which appear at page 73 in the Hearing Committee Determination indicate that the Respondent is not a candidate for rehabilitation. Since the Committee has determined that the Respondent is guilty of multiple and gross acts of negligence in treating patients and concluded that the Respondent should not continue practicing surgery, and since the Review Board can see no other means to protect the public health in this case, we determine that the only appropriate penalty in this case is to revoke the Respondent's license to practice medicine in New York State.

ORDER

NOW, based upon this Determination, the Review Board issues the following ORDER:

1. The April 2, 1993 Determination by the Hearing Committee on Professional Medical Conduct finding Dr. Gerald Moss guilty of gross negligence, negligence on more than one occasion and failure to maintain adequate records is sustained.

2. The Hearing Committee's penalty limiting the Respondent's license to consultations is overruled.

3. The license of Gerald Moss, M.D. to practice medicine in the State of New York, is revoked.

ROBERT M. BRIBER
WINSTON S. PRICE, M.D.
MARYCLAIRE B. SHERWIN
EDWARD C. SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF GERALD MOSS, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Moss.

DATED: Albany, New York
July 30, 1993

s/MaryClaire B. Sherwin
MARYCLAIRE B. SHERWIN

IN THE MATTER OF GERALD MOSS, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of GERALD MOSS, M.D.

DATED: Brooklyn, New York
July 27, 1993

s/Winston S. Price
WINSTON S. PRICE

IN THE MATTER OF GERALD MOSS, M.D.

EDWARD C. SINNOT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Moss.

DATED: Albany, New York
July 26, 1993

s/Edward C. Sinnott, M.D.
EDWARD C. SINNOTT, M.D.

IN THE MATTER OF GERALD MOSS, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Moss.

DATED: Albany, New York
July 7, 1993

s/Robert M. Briber
ROBERT M. BRIBER

IN THE MATTER OF GERALD MOSS, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Moss.

DATED: Albany, New York
August 4, 1993

s/William A. Stewart, M.D.
WILLIAM A. STEWART, M.D.

New York State Department of Health State Board for Professional Medical Conduct Hearing Committee Determination and Order, dated March 24, 1993.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS,

DETERMINATION AND
ORDER OF THE
HEARING COMMITTEE

Order No. BPMC-93-52

The undersigned Hearing Committee consisting of JOSEPH K. MYERS, JR., M.D., F.A.C.S., Chairperson, ROBERT A. MENOTTI, M.D., F.A.C.S., and GEORGE F. COUPERTHWAIT, JR., was duly designated and appointed by the State Board for Professional Medical Conduct. DAVID A. SOLOMON, ESQ., Administrative Law Judge, served as Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230, subdivision 10, of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by GERALD MOSS, M.D. (hereinafter referred

to as the "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the Hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its' decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	August 5, 1992
Affidavit of Service:	August 7, 1992
Ammendment of Paragraph A.3:	September 10, 1992
Withdrawal of Paragraphs C.1 & E.3 of Statement of Charges of stipulation of Parties with the concurrance of the Chairperson:	November 12, 1992 January 21, 1993
The State Board for Professional Medical Conduct appeared by:	Kevin P. Donovan, Esq. Assistant Counsel Bureau of Professional Medical Conduct 2429 Corning Tower Bldg. Empire State Plaza Albany, NY 12237

Respondent appeared in person represented by:

Gleason, Dunn, Walsh & O'Shea
11 North Pearl Street
Albany, NY 12207
by: Thomas Gleason, Esq., of Counsel

Locations and dates of Hearing and Conferences:

All Hearings and Conferences were Conducted at:

Professional Medical Conduct
Assigned Hearing Rooms
Corning Tower & Justice Bldgs.
Empire State Plaza
Albany, New York 12237

Hearing Dates:

August 28, 1992
September 10, 1992
October 29, 1992
November 12, 1992
November 13, 1992
November 17, 1992
December 8, 1992
December 14, 1992
December 23, 1992
January 6, 1993

Conference Dates:

Pre-Hearing Conference: August 19, 1992
Intra-Hearing Conference: September 10, 1992
Intra-Hearing Conference: November 12, 1992

Submission by the Respondent of an Affidavit of his Expert Witness for Inclusion in the Record only: February 3, 1993

Submission by the Petitioner of a Letter/Memorandum in Reply to the Respondent's Affidavit Request: February 9, 1993

Determination of the Administrative Officer Denying Inclusion of the Expert's Affidavit in the Record: February 10, 1993

Request by the Petitioner that the Hearing Committee be instructed at the February 10, 1993 Deliberations Meeting not to consider page 74 through the first four lines of page 79 entitled Dismissal of Charges Due to Delay and Lack of Due Process: February 9, 1993

Submission of Findings of Fact by the Parties: February 5, 1993

Deliberations of the Hearing Committee: State Department of Health, South Salina St., Syracuse, NY February 10, 1993

Closing of the Record February 10, 1993

Letter Orders of the Administrative Officer on Affidavit of Expert Witness and Laches & Due Process: February 15, 1993

Letter Order re Reply
Ammendment: February 22, 1993

NOTE: Respondent waived the 120 and 60 day time limits set forth in Sec.230 (10) (f), (h). T.1789-1791.

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges inappropriate, inadequate or otherwise deficient treatment of five patients by the Respondent. It is alleged Patient A, B and C were inappropriately discharge from the hospital and inadequately evaluated and treated after discharged and that Respondent's post-operative hospital and office notes were inadequate. Inappropriate hospital discharge of Patient D is alleged. Inadequate pre-operative preparation of Patient E's bowel is alleged, as is improper use of Vivonex and several inadequacies of Respondent's operative note.

In his opening statement, the Respondent denied premature discharge in each case. He also spoke to ". . . substantial predjudice as a result of the delay" despite denial of his motions based on the same objection at the pre-hearing conference that preceded the hearing. T. 10; Pre-hearing Conference T.63-64.

Ammendments to the Statement of Charges on stipulation of the parties were to allegation A.3 to read:

> Respondent's post-operative hospital and office notes for Patient A are inadequate. T.405-406, 633.

And allegations C.1 and E.3 were withdrawn. T.632-633, 1/21/93 Letter to the Parties.

The respondent did not file a written answer or an affirmative defense related to his time delay objection. See, 10 NYCRR 51.5 (c), 51.11 (d) (10).

The allegations are set forth more particularly in the Statement of Charges attached hereto as Appendix I. The above noted ammendments are referred to in the margins.

At the Pre-Hearing Conference, the Respondent questioned concerning the possible bias of the Chairperson who had informed the Administrative Officer of the Petitioner's expert witness being an acquaintance. Subsequently, the Respondent filed two affidavits requesting replacement of the Chairperson. The Administrative Officer filed a Determination on November 12, 1992:

> It is determined that the facts presented do not meet the substantial liklyhood threashold of bias required for the disqualification of Dr. Myers as a member of the Hearing Committee. ALJ Exs. 1, 2
>
> The Ruling on Bias Request is attached as Appendix II.

As late as the last day of the hearing the Respondent cross examined witness Dr. Guest on factual matters related to his rejected affirmative defense of a time delay. And he included it as well as in his Findings of Fact and Conclusions of Law. On the request of the Petitioner, the Administrative Officer informed the Hearing Committee that they should not consider the pertinent pages of Respondent's proposed findings in preparing their own. Department rules are explicit in prohibiting consideration of any time delay less that one year; herein, the "delay" is 21 days. 10 NYCRR 51.11 (d) (01).

"Petitioner's Motion to Instruct the Hearing Committee Not to Consider Pages 74 through 78 of the Respondent's Proposed Findings" was filed on February 15, 1993. The Administrative Officer's notice to the attorneys had a like date. Both, with any Reply received from the Respondent, are attached hereto as Appendix III.

The notice to the parties on the Committee's instruction notes that the Respondent did not meet the Rule requirement that it be in the form of an affirmative defense. The three day notice prior to the initial hearing date was met by making the motion at the Pre-Hearing Conference. Regardless of the mandated proceedure the burden of proof is on the Respondent. It was not met.

The Respondent submitted an affidavit of a medical expert witness, Edward Saltzstein, M.D., for inclusion in the record only. The Administrative Officer denied the request and returned the affidavit and the reply letter to the attorneys. The decision is Appendix IV.

The State called the following witnesses:

Patient B	Fact Witness
Mrs. B	Fact Witness
Mr. B	Fact Witness
Patient A's Son-A	Fact Witness
Patient A's Daughter-in-law-A	Fact Witness
Patient A's Son-B	Fact Witness
Patient A's Stepdaughter	Fact Witness
Patient A's Husband	Fact Witness
Patient C	Fact Witness
Richard D. Eberle, M.D.	Expert Witness
Patient A's Daughter-in-law-B	Fact Witness
C. Maynard Guest, M.D.	Fact Witness

Respondent testified in his own behalf and called the following witnesses:

Arthur D. Stein, M.D.	Expert Witness
Robert J. Suozzo, M.D.	Expert Witness
James M. Gavin, M.D.	Fact Witness
Edward C. Saltzstein, M.D.	Expert Witness
Mary Ellen Regal, R.N.	Fact Witness

SIGNIFICANT LEGAL RULINGS

Official Notice was taken by the Administrative Officer, with the concurrence of the Hearing Committee, that the phrase "vital signs" consists of temperature, blood pressure and respiration. Such facts are within the specialized knowledge of the New York State Department of Health. 10 NYCRR 51.11 (d) (4).

During the course of the Hearing, the Hearing Committee had access to and consulted a memorandum dated February 5, 1992, entitled "Definitions of Professional Misconduct under the New York Education Law" by Peter J. Millock, Esq., General Counsel for the Department of Health. This document contains suggested definitions for gross negligence and negligence on more than one occasion. Negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances or deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that Petitioner establish that injury actually resulted from the deviation. Gross negligence has been defined by New York's highest court to be "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct" *Roh v. Ambach,* 74 NY2d 318, 322 (1989). Egregious means conspicuously bad. *Spero v. Board of Regents,* 158 AD2d 763, 764 (3rd Dept. 1990).

Concerning the charges of failure to maintain adequate medical records, the Committee adopts the standards set forth by

the court in *Schwartz v. Board of Regents,* 89 AD2d 711 (3rd Dept. 1982). That case established the definition of what constituted adequate medical records well in advance of the cases at issue here. In *Schwartz* the court rejected a physician's contention that records are accurate if they can be interpreted by the treating physician. The court stated that records are adequate if they would provide meaningful medical information to other practicioners should the patient transfer to a new physician or the treating physician be unavailable for any reason (Schwartz at 712). The court referred to the standard as requiring "objectively meaningful medical information" (*Id.).*

FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise. The findings and conclusions of the Petitioner and Respondent submitted herein were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings of fact were made after review of the entire record. Numbers following a finding refer to page numbers of the transcript (T. ___). Numbers and letters following a finding preceded by a reference to exhibits (Ex. ___) refer to exhibits in evidence. The citations represent evidence the Committee found persuasive in arriving at a particular finding. All findings of fact were established by at least a preponderance of the evidence. Evidence which conflicted with any finding of the Hearing Committee was considered and rejected. The extent that one expert or witness's opinion was given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. Respondent Gerald Moss, M.D. was authorized to practice medicine in New York State on July 20, 1962, having been

issued license number 087923 by the New York State Education Department. The Respondent is currently registered with the NYS Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 with a registered address of Climer Circle, Box 296, West Sand Lake, New York 12196. Ex. 2.

2. Respondent was personally served with the Notice of Hearing, Statement of Charges, and Summary of Department of Health Hearing Rules on August 7, 1992. Ex. 1. He personally appeared in this proceeding and was represented by Counsel. T.6.

3. Evidentiary hearings were held in this matter on the following dates in 1982: August 28, September 10, October 29, November 12, 13 and 17, December 8, 14 and 23 and on January 6, 1983.

4. The Statement of Charges was amended on September 10, 1992, so that paragraph A.3 would read: "Respondent's post-operative hospital and office notes for Patient A are inadequate." T. 405-406, 633. Two further amendments withdrew allegations C.1 and E.3. T. 632-633 and ALJ Letter dated 1/21/93, respectively.

A. PATIENT A. (Gross Negligence, Negligence)

5. Patient A was an 85 year old female when she visited the Respondent's office on June 8, 1983, complaining of a ventral hernia. Ex. 5, p.1; see, Ex. 3, p.1.

6. Patient A was admitted by Respondent to Samaritan Hospital, Troy, New York, on July 7, 1983. An operation to repair her ventral hernia was performed from 9:50 a.m. to noon on July 8, 1983. Ex. 3, pp. 1, 28, 29. A ventral hernia is the weakness or

separation of the fascia with a herniation through the defect. T. 484-485. The hernia was the result of prior surgery in her abdomen, and was about 8 inches long and about 4 inches wide and extended from her xiphoid to pubis. Ex. 3, p. 29; T. 877-878. The hernia was fully reducible, meaning that all of the abdominal contents could be contained in the abdominal wall flat and the abdomen could be closed. T. 879.

7. During the course of the July 8 surgery to repair the ventral hernia, Respondent inadvertently lacerated the Patient's small bowel. Ex. 3, p.29. As a repair, Respondent removed a section of the small intestine and closed the opening in the small bowel with a stapling instrument. Ex. 3, pp. 29-30; T. 882-883.

8. Respondent agreed that discharge criteria for Patient A would be eating, drinking and keeping it down. T. 938-939. He then tried to qualify this statement by stating that for this Patient that would mean net nutrients and liquid taken in and kept down. T. 939.

9. By 8:00 p.m. on July 8, the date of the operation, Patient A's temperature had risen to 101.9 degrees; at midnight, it was 101.4; it fell to 98.8 at 4:00 a.m. on July 9, rose to 101.4 at 8:00 a.m. and 102.1 at noon, and then fell to 98 degrees at 4:00 p.m. No temperature readings are recorded after 4:00 p.m. Ex. 3, p.9. Patient A was not discharged until 7:00 p.m. Ex 4, p.3.

10. On the date of discharge, Patient A vomited 350 cc's of brown fluid during the 7:00 a.m. to 3:00 p.m. shift, and 150 cc's of undigested food at about 6:00 p.m. Ex. 3, p. 37.

11. The laceration of the small bowel changed the way this case should be considered using acceptable standards of medical care, from one of only ventral hernia repair to one of ventral

hernia repair and lacerated small bowel. Such changes the case because of the possibility of complications from contamination from the lacerated bowel and possible leak from the repair. T. 379.

12. Before discharge, Patient A was still vomiting. Before discharge, there was a questionable stability of Patient A's temperature. Dr. Eberle concluded that Patient A was not stable at the time of discharge. T. 449-451, 508-510; Ex. 3, pp. 9, 37.

13. Dr. Eberle's opinion was that the discharge of Patient A on July 9, 1983 did not meet acceptable medical standards because the Patient was not stable and therefore not in appropppriate discharge condition. T. 385.

14. A reasonably prudent surgeon being aware of persistent complaints of pain and vomiting in the post-operative period would be concerned that something was going on in the abdomen. Dr. Eberle could not state exactly what was occurring without examining the abdomen; it could be a perforation, an obstruction or a number of things that can occur after repair of a small bowel. T. 427-429. Dr. Eberle clearly stated that the decision to discharge Patient A was inappropriate. T. 436. Dr. Eberle explained that the advantages of monitoring an inpatient versus an outpatient are that vital signs can be taken more frequently on a surgical floor, the patient's intake and output can be measured, bowel can be evaluated for functioning, and a patient is examined by a physician one or two times a day. T. 436.

15. Respondent attempted to explain Patient A's first vomiting episode of 350 cc's of brown fluid on the date of discharge by asserting that the naso-gastric tube stimulates a gag reflex, but it was a large amount of liquid and the brown color indicated it

could be bile. T. 901. Respondent stated he did not know whether 350 cc's of brown liquid would reasonably be expected. T. 902.

16. As an explanation for the second incident of vomiting 150 cc's of undigested food at 6:00 before discharge an hour later, Respondent stated he was concerned, but he would expect it, as the hernia repair meant the patient could not accommodate her normal eating and drinking habits. T. 904.

17. A cause of post-operative fever in Patient A could be atelectasis, a collapse of a portion of the lung. It is a common cause of fever within 24 to 36 hours of surgery; other causes of fever include urinary tract infections, intraabdominal infection, peritoneal infection, bleeding, acute pulmonary infections, and others. T. 442-443. A prudent practicioner would consider causes for fever other than atelectasis. T. 1495.

18. While it is a reasonable deduction that coughing of the Patient could have reduced atelectasis and apparently cause a fever to come down, only one normal temperature was recorded prior to discharge and the Patient was not watched long enough to assure the temperature did not go back up. Patient A's temperature was last taken at 4:00 p.m.; her discharge temperature was not known. T. 448.

19. A prudent general surgeon would have watched the temperature of Patient A for a period of time before being able to conclude that atelectasis had caused the fever and that the coughing had cleared the atelectasis to permit the temperature to stay down. T. 509-510.

20. Respondent testified that he thought some of the 350 cc's of vomit Patient A had on the day of discharge was due to the fact

that she had just eaten; however, when it was pointed out there was no indication of food in the vomit, he stated it might have been only liquid. T. 949.

21. While the Respondent wished to tie the Patient's first episode of vomiting on the day of discharge to the Moss tube being removed, there was no specific statement as to when Patient A vomited other than that it was on the 7 to 3 shift; the tube would have been removed shortly after 6:30 a.m.. T. 953. The notations of vomiting are written at the midpoint of the 7 to 3 shift narrative. Ex. 3, p. 37.

22. Respondent admitted that a patient who had a small bowel laceration during surgery with fever, nausea and vomiting within 24 to 36 hours of surgery, could have an intestinal obstruction. T. 950-951.

23. Dr. Saltzstein, presented as the Respondent's expert witness, candidly testified that he had a concern about Patient A's case, that he would not have fed and discharged her as Respondent did. T. 1410-1411. When asked to discuss both the fever and vomiting, Dr. Saltzstein stated he believed the fever was pulmonary, that he would have been concerned about it and the vomiting, that he would not have discharged Patient A, and that he was not trying to defend the Respondent under these circumstances. T. 1460. Dr. Saltzstein refused to believe a resident under his supervision would discharge Patient A; but, when asked to assume a resident had done so, he stated there would have been an "education process" for that resident. T. 1478-1479. Dr. Saltzstein testified that if he were presented with the facts on this patient in an examination, the best answer would be not to send the patient home. T. 1481. He would expect most practicing general surgeons to keep the patient in the hospital. He would not have sent Patient A home; he would

have instructed his residents not to do so. T. 1484. In short, Dr. Saltzstein repeatedly implied that the discharge of Patient A was inappropriate.

24. In Respondent's videotape he set forth discharge criteria, which included that the patient must be eating and drinking and keeping it down, must show bowel function by passing gas and moving bowels, and must be afebrile. Ex. F-1; T. 1114; Appendix to 11/17/92 Transcript at 13.

25. The records state the 350 cc's that Patient A vomited did not contain any food; it was a brown fluid. The Respondent stated that it could have contained bile. He also stated that any excess, undigested food vomited never contained bile. T. 1115.

26. Despite Respondent's contention that the discharge criteria he set forth for cholecystectomy patients did not apply to Patient A, the transcript of Respondent's tape demonstrates that after his discussion of discharge criteria, he stated: "Cholecysectomy is not the only abdominal procedure to which this is applicable." T. 1116; Appendix to 11/17/92 transcript at 13-15.

27. The Respondent's medical expert witness, Dr. Saltzstein, stated that if the patient continued to vomit after being fed, the patient needs to be evaluated for the reasons why. T. 1460. Vomiting can be a response to a lot of things, including problems with the gastrointestinal tract. T. 1459.

28. Two days after hospital discharge, on July 11, the Patient was taken to Respondent's office. Respondent was told the Patient was in a lot of pain and was vomiting. A daughter-in-law and a stepdaughter of the Patient, both of whom were present during the entire visit, testified no temperature, blood pressure

or pulse was taken, and there was no use of a stethoscope or touching of the Patient's abdomen. T. 140-142, 185.

29. Respondent did not perform an adequate physical examination of Patient A at the office visit on July 11, 1983. T. 396. To meet acceptable standards of medical care, a temperature should have been taken, pulse and respiration recorded. The Respondent should have examined the chest and lungs, and the abdomen by palpation and auscultation (feeling and listening), and with his stethoscope. T. 396. A lung examination should have included palpation, thumping on the chest, and listening with a stethoscope. T. 396-397. Dr. Saltzstein agreed that the usual course for a patient who had an abdominal procedure is to examine the abdomen by palpation. T. 1485.

30. On July 12, 1983, the day after the office visit, the Respondent was informed by two of Patient A's sons that she was in a lot of pain. T. 116-117, 165, 187. Respondent's response to the information did not meet acceptable standards of care in view of the previous events. T. 398-400.

31. Respondent's response was not adequate because it was now the third day post-operatively and the Patient was still having problems, pain and trouble for some reason. One still has to worry about the sutured bowel as a possible source of the symptoms. T. 399. An appropriate response to the phone calls would have been to have seen the Patient that very day even though she had been seen just the day before; upon seeing her on July 12th, the Respondent should have adequately examined her. T. 399-400.

32. Respondent did acknowledge that there were multiple telephone calls by Patient A's relatives to him complaining of Patient A's pain and that his suggestion was that the Patient be

walked. T. 917. Respondent stated: "I was getting calls and making calls relatively continuous, more so than the average patient. For the average patient it would be about three or four phone calls maximum." T. 919.

33. Later in the evening of July 12, 1983, at about 9: p.m., Patient A's other son, who was aware a call had already been made that evening to Respondent, called Respondent. T. 164-165. The son told Respondent that Patient A was in a lot of pain, and that while the Patient can stand a lot of pain, this is beyond that, and that something should be done. T. 165. Respondent told the son that there was nothing wrong with the Patient and that she could do anything but drive a car; the son replied that the Patient could not even get out of bed. T. 165-166. Respondent stated Patient A had to get out of bed and walk in order to get rid of the gas. T. 166. Patient A's son stated she was in so much pain she could not get out of bed and asked what Respondent recommended for gas; he recommended Mylanta. T. 166.

34. Petitioner's expert stated that this was not an adequate response to the information given to the Respondent. T. 401. He now has the additional information that Patient A is weak and cannot walk; she has persistent pain not relieved by enema. T. 401. Respondent should have seen her that day and adequately examined her. T. 401.

35. Later that night, at approximately 3:00 a.m. on July 13th, Patient A's step-daughter called Respondent and told him that the Patient was crying with pain, was really bad off. T. 188. The step-daughter also suggested possibly returning Patient A to the hospital. T. 192. Respondent replied that he would give her an appointment to see him at 8:30 in the morning. T. 192.

36. Respondent's response to such information did not meet acceptable medical standards. T. 402. He should have seen the Patient as soon as he possibly could given all of her symptoms and lack of response to suggested treatment. T. 403. He should have seen her himself by meeting her at the office or in the emergency room. T. 403. Even though Respondent did schedule an appointment for only 5 ½ hours later, the delay between the telephone call and the appointment was unacceptable because of everything that had happened since Patient A left the hospital. It suggested something bad was going on and she should be seen as soon as possible. T. 404. The Patient should have been seen immediately particularly when there were two or more phone calls within a short time of each other. T. 404.

37. Within a few hours after the 3:00 a.m. call to Respondent on July 13, 1983, Patient A collapsed, was taken to the hospital by ambulance, and died. Exs. 6, 7.

38. Respondent admitted he was told Patient A was continuously vomiting small amounts of food after she ate and drank. T. 915-916. Respondent preferred to attribute this vomiting to his assumption she was consuming large amounts of food and the fact she was obese. T. 916, whereas Patient A's daughter-in-law, who was with Patient A, testified that in fact she was "eating" tea and toast and not keeping it down. T. 191.

39. Respondent remembers having perhaps a total of four conversations with Patient A's family on October 12, more than usual for a post-operative patient, coinciding with the testimony of Patient A's family. T. 965, 971.

40. When presented with the facts that Respondent himself testified to, namely multiple complaints that Patient A was vomiting after eating on more than one occasion and was having

pain, Dr. Saltzstein testified that he would not be as concerned about the pain as the vomiting, both from the standpoint of whether Patient A was appropriately nourished and also whether she could have bowel obstruction and whether her gastrointestinal tract was intact. T. 1462-1463. Dr. Saltzstein would want to evaluate the patient personally; he would either see the patient at her home or in the hospital. T. 1463.

A. PATIENT A., CONT'D. (Inadequate Records)

41. Dr. Eberle stated that Respondent's second hospital progress note for July 9, 1983 was not adequate. Ex. 3 at 4; T. 407.

42. Adequate physician notes are important in the hospital record as they should indicate the thought processes of the physician concerning the patient at the time the note is written. The physician should have a record of his thought processes at a later time. If another physician takes over care, the physician can determine what the treating physician thought at the time the note was written. In addition, it is an indication of the quality of care being rendered. T. 408-409; and see, Significant Legal Rulings, *supra*, p. 8.

43. Respondent's office record does not contain an adequate post-operative record of Patient A in view of acceptable medical standards because it should reflect the examination performed. The vital signs including temperature, and adequate lung and abdominal examination would need to be recorded. Ex.5; T. 409-410.

44. Concerning the adequacy of Respondent's hospital notes, Dr. Saltzstein stated they were "a little scanty," that he would have liked to see more information, and that the positive finding of vomiting was not recorded by Respondent. T. 1465. Dr.

Saltzstein stated, that for a patient who had fever and vomiting after abdominal surgery, he would like to see those events noted by the physician and explanations for why, nonetheless, the patient was discharged. T. 1465-1466.

45. Dr. Saltzstein's opinions on the adequacy of Respondent's notes were based on his opinion that, though the notes were relatively cryptic and it was difficult to determine what was meant, that no standard existed for office notes. T. 1432. As noted in this determination, the case law in New York State does, and did in 1982, establish a standard. Dr. Saltzstein stated the notes were written for the purposes of the person caring for the patient. T. 1432-1433. New York Law requires "objectively meaningful medical information" to other practicioners should the patient transfer to a new physician or the treating physician is unavailable for any reason. Significant Legal Rulings, *supra,* p.8.

B. PATIENT B (Gross Negligence, Negligence)

46. Patient B was a 47 year old male when he entered Albany Memorial Hospital, in Albany, New York, on October 2, 1983, to have a cholecystectomy or gall bladder removal performed by the Respondent. Ex. 8 at 1.

47. During the operation, dissection of the gall bladder was difficult as it required "digital exploration," and Respondent noted that it was difficult to identify "planes and structures." T. 523-525, 1020-1022.

48. The surgery was performed on the patient on October 3, 1983, and he was discharged at about 6:30 p.m. the next day, October 4th. Ex. 8 at 18, 45.

49. Between the conclusion of the surgery on October 3 and discharge of the patient on October 4, his temperature, pulse, and respirations became and remained elevated. The patients rectal temperature became elevated to 101 degrees beginning at midnight after the operation of October 3 and remained at that level until the last reading prior to discharge demonstrated an oral temperature of 100.2 degrees at 4:00 p.m. on October 4th. The patient's pulse elevated post-operatively to 120 and had decreased to 90, and the patient's respirations elevated to 40 post-operatively and had dropped to 30 at 4:00 p.m. on October 4. Ex. 8 at 31.

50. Dr. Saltzstein, confirmed the vital signs of Patient B were consistent with a reasonable medical decision to discharge Patient B on October 4th. Ex. 8, p. 31. The discharge of the Patient on the day after surgery was appropriate, the record confirming that a normal progression of recovery was in progress. T. 1498-1501; Ex. 8, pp. 12, 22.

B. PATIENT B. (Records)

51. A post-operative physical examination should include the patient's temperature as a part of the follow-up of the patient. There is no indication whether such was or was not done. T. 1532-1533; Ex. 9.

52. Respondent's post-operative hospital progress notes did not mention signs of instability of Patient B's vital signs. T. 530-531.

53. Respondent's hospital progress notes contain no indication that Respondent was aware of Patient B's elevated respirations pulse or temperature. T. 1137-1138.

54. Respondent admitted his post-operative hospital and office notes are inadequate measured against 1992 standards. He does not belive that 1984 standards were not met. T. 1148. The case law and regulatory requirements of 1992 were in effect in 1984. Significant Legal Rulings, *supra.*, p. 8.

55. On the day after discharge from the hospital, October 5, Patient B's wife called Respondent stating the Patient did not look good, that he was very pale with a yellowish tinge and that she was concerned about his color. She is not a trained medical observor; jaundice and pallor were not established to the satisfaction of the Committee. T. 69, 75.

56. Both Patient B and his wife identified soaking sweat as a characteristic of Patient B's condition prior to his office visit with Respondent on October 9th. T. 62, 70-71.

57. Patient B, his wife and son stated severe pain was also a second problem reported on the October 9th visit to the Respondent T. 27, 34, 70-72, 92.

58. Following the office visit of October 6th and before the next visit on October 9th, Patient B's wife called and told the Respondent that her husband's color was bad. T. 70. Early Sunday morning, October 9th, Patient B's wife called the Respondent again and told him Patient B had been up most of the night, was in severe pain, a profuse cold sweat, and was cold and clammy. T. 71. Respondent told the Patient's wife to have Patient B at his office within the hour. T. 71.

59. Patient B's son drove him to Respondent's office on October 9. During the drive the Patient asked his son not to hit bumps or go around corners fast, and he complained of pain when the car hit a bump. T. 92. The Patient's son helped his father in and out

of Respondent's office; his father was hunched over when walking. T. 92, 93. The son waited in the waiting room; following the visit, Respondent stated to Patient's son "Everything is going pretty good, right on schedule." T. 93.

60. Dr. Saltzstein stated that based on the medical record, he felt post-surgical care by the Respondent was acceptable. T. 1511. He also stated the office entry October 9 contained no statement of what Respondent did or did not due at the office visit. T. 1519. He stated it just was not possible for him to interpret the notes of the Respondent. T. 1519. After being informed that New York Law required a physician to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, Dr. Saltzstein stated the records did not indicate to him what Respondent did or did not do. T. 1520. He stated the notes do not reflect an evaluaiton either done or not done. T. 1521.

61. Dr. Eberle testified that Respondent did not take an adequate history or perform an adequate examination of Patient B at the office visit on October 9. T. 537. Based on the fact that Patient B was in distress, on the information provided by his family, and knowing the difficult dissection, Respondent should have asked the Patient how he felt, what was bothering him, whether he had pain, whether there was anything that the Patient was complaining about that was normal or abnormal. He should have examined the abdomen and indicated in the note that he did examine by palpation, ausculation and observation. T. 537. There is no evidence from Respondent's office record that an adequate physical examination of the Patient was performed at the office visit of October 9. T. 537, 539-540.

62. Petitioner's expert further testified that Respondent's office record entries for October 6 and 9, 1983, do not meet acceptable

standards of medical record keeping because they do not give evidence of the exact condition of the Patient and do not address complaints that were apparently present. T. 542. Considering the fact that the Patient had a difficult cholecystectomy and the possibility of complications, acceptable standards of medical care require evidence that the abdomen was examined and what the examination showed, rather than just a statement that the wound is clean and the hematoma drained T.542.

C. PATIENT C.

63. Patient C was 53 years old when he was admitted to Samaritan Hospital in Troy, New York, on April 13, 1984, by Drs. Sullivan and Moss for evaluation of a possible gall bladder problem. Ex. 11, pp. 2-5. He was diagnosed as having acute cholecystitis, and a cholecystectomy was performed on April 13, 1984. Ex. 11, p. 32. the pathology report found that: "The patient had acute suppurative cholecystitis with focal necrosis and much hemorrhage." Ex.11,p.33

64. Over the course of Patient C's stay at the hospital and before his discharge, his red blood count, hemoglobin and hematocrit declined. T.598. The last hematology report prior to the Patient's discharge showed a white blood cell count of 12,500, with polys of 81 and stabs of 9. T. 599; Ex. 11,p.18. Stabs are immature and polys mature white blood cells. T. 646-677.

65. The change from two to nine stabs is called a "left shift" which indicates immature forms of white cells which means an inflammatory or infectious process. T. 1591..

66. The Patient was discharged at 7:30 p.m. on April 14, 1984. Ex. 11, p. 39.

67. Dr. Saltzstein stated that waiting for a patient to have a bowel movement is not a valid reason to keep a Patient in the hospital. It could take a day or two or more. If there is evidence that the patient has gastrointestinal function, tolerating liquids, that they can be discharged, one doesn't have to wait for a bowel movement. T. 1588.

68. Respondent's post-operative progress note dated 4/14/84 does not meet acceptable standards of record keeping because it does not address the issues presented by the contents of the hematology reports and by the comments in the nursing notes concerning not having a BM, and a distended abdomen. T. 601-602. If the Respondent had made that progress note in the morning prior to the events noted in the nurse's notes, he should have addressed those items in a later note. T.603.

69. On April 15, the Respondent saw Patient C at his office. T. 232. Respondent looked at the Patient's abdomen and touched around the incision area, but did not take the Patient's temperature, blood pressure or use a stethoscope, T. 233.

70. Respondent's notes do not indicate that he adequately addressed the complaints concerning the Patient. T.604.

71. On April 16, Respondent was called and told that Patient C was in pain in his side around the right arm; Respondent stated that was expected with surgery. T.278. On April 17, Respondent was called again and told by Patient C's wife that the Patient had pain further down his right side and that he was not eating right. T. 278-279. Respondent replied that pain was to be expected with surgery and he would see the Patient on the 18th, the next day, for a previously scheduled appointment. T. 279.

72. Dr. Eberle stated that with these continued complaints of pain, Respondent should have seen the Patient earlier than the scheduled appointment on the next day. T. 605.

73. At the office visit on April 18, 1984, Respondent was told that the Patient was not feeling well, that he had pain in his right side, and that he was having hiccoughs. T.279. He was told also that the Patient was only eating Jello and a little toast, but nothing else, and that the Patient was not sleeping well T. 279. Further, the Respondent was told at the office visit of the 18th that the Patient felt bloated and could not go to the bathroom. T.280 Respondent gave the Patient Maalox to take, and indicated that these things went along with the surgery. T. 280. He did not take the patient's temperature or blood pressure. T. 281.

74. Petitioner's expert testified that Respondent did not adequately evaluate the Patient at the office visit on April 18; it would be necessary to examine the chest and abdomen. There would be concern about diaphragmatic irritation with the hiccoughs. T. 606.

75. Respondent described his examination of Patient C at the office visit of April 15. It included only looking at the Patient as he walked to observe his breathing pattern, touching his hand to feel a pulse rate and noting his general appearance. When the Patient lay down on the examining table it was only to examine the wound and apply general pressure to see if there were tenderness. T.1160-1161. Respondent testified to a similiar examination being performed on April 18. T.1161-1162. Notably absent were the elements of an examination which Dr. Eberle testified should have been performed, such as examination of the abdomen and chest. T. 606.

76. In the early morning hours of Sunday, April 20, Respondent was called by Patient C's wife and told that her husband was vomiting, that he had a fever, that he was trying to go to the bathroom but couldn't, that he felt he had gas but could not relieve it. T.280-282. Respondent stated that the Patient should be brought to his office at 8:00 a.m. T. 282.

77. Respondent recalls receiving the phone call from Patient C at 5:00 or 6:00 a.m.on April 20 complaining of a fever and pain in the lower part of his right chest when he took a breath. T.1166.

78. Respondent told Dr. Gavin's staff to take a chest x-ray. T. 1168.

79. At the office visit on the 20th the Patient complained about pain when he took a deep breath, severe pain at the rib margin on the right. T.1170. Respondent was again told the Patient had vomited through the night, had a temperature, felt like he had to go to the bathroom but couldn't, that the pain was still in the right hand side of his body, that his stomach was starting to get larger, and that he was having hiccoughs and they were quite evident. T.282.

80. Respondent diagnosed the Patient as having atelectasis. Ex. 12, p. 4.

81. A chest x-ray of Patient C demonstrates that the right diaphragm is high and there may be some of atelectasis and/or interstitial, interlobar effusion. T.609-610; Ex. 13A A reasonably prudent surgeon seeing that x-ray of a patient who had had a cholecystectomy seven days before should consider the causes of the elevation of the right diaphragm, which could be atelectasis, or something below the diaphragm pushing it up. T.610. The elevated diaphragm needs an explanation. T.611.

82. Given the information provided to Respondent at the office visit on the 20th and the information provided before then, considering what is shown on the x-ray of the Patient, and the facts noted in Respondent's office record (Ex. 12), Respondent did not perform a complete evaluation of the Patient as there is no indication in the office record concerning his findings about the Patient's abdomen. T. 607, 612-613. Given an operation that was below the diaphragm, with a Patient who has pain, elevated diaphragm, a fever, there is need to look at and evaluate the abdomen before deciding that the problem was in the chest. T. 613.

83. Looking at the x-ray (Ex. 13A), Dr. Saltzstein stated that an elevated right hemi-diaphragm would make one consider the possibility of something going on under the diaphragm. T.1615. He also testified that the other x-ray (Ex.13B), shows that the right diaphragm is higher than usual and that there was some blunting of the costophrenic angle which indicates that there may be some fluid in the lung T.1616. The pleural effusions on this Patient's x-ray would indicate the possibility of something going on below the diaphragm. T.1628.

84. Petitioner's expert stated that Respondent diagnosed atelectasis which is unusual by the seventh post-operative day. There is no record of abdominal examination although this was an intra-abdominal operation, and the elevated diaphragm as shown by the chest x-ray is more likely to have been caused by something below the diaphragm. T. 625.

85. The Patient had lower chect pain which can be caused by something below the diaphragm, particularly when the diaphragm is elevated. T.626.

86. Respondent stated the x-ray would indicate to him the possibility of something beneath the diaphragm (T.1251, Ex.13A), but he rejected that because the patient's complaints related only to respiratory problems in the right chest. T.1251. He did testify that there could be a sterile irritating collection even in the absence of fever and signs of inflammation. T. 1252.

87. The physician who evaluated Patient C on April 21 at the emergency room for a second hospitalization noted that Patient C had hiccoughs, and the physician who performed his admitting history and physical also noted that the Patient had a complaint of hiccoughs. Ex. 11, pp. 49, 51.

88. Respondent's stated plan of treatment for the Patient on April 20, 1984 does not meet acceptable standards of medical care. T. 623-625. The plan of care was for the Patient to take Ampicillin, steam, encourage coughing, and call Dr. Gavin in 3 days if symptoms persist. Ex. 12, p. 4.

89. Dr. Eberle testified that the office records of Respondent for the office visits of April 18 and 20 do not meet acceptable standards of medical care for record keeping because of a lack of notation of an abdomenal examination other than an observation that the wound was clean. Too, no physical findings of a chest examination on April 20th is noted, only a diagnosis. T. 622-625, 626-627; Ex. 12.

90. Respondent's office records for April 20 does not contain adequate information for Dr. Gavin to take over care of this Patient, nor does it contain any information about any problems that the Patient had earlier than one day before the 20th. T. 685-686.

91. Respondent testified that he would not have considered an abscess with his Patient as he thought it would be too soon with this Patient's history. T. 1253. Respondent said that if the abscess raising the diaphragm were the result of infection, the Patient would have a temperature, but then acknowledged that his own office record demonstrates the Patient had a one day history of a 101 degrees temperature by the 20th. T. 1255. Respondent also stated that there is a high incidence, about five percent, of infection after acute cholecystitis. T. 1255.

92. Respondent agrees that post-operative care is directed at preventing and promptly recognizing and treating complications after cholecystectomy, such as subphrenic abscess. T.1256-1257. One of the reasons the right diaphragm may be elevated on the x-rays is an abscess. T. 1257.

93. Dr. Saltzstein agrees that, while the majority of patients might lend themselves to early discharge, a prudent physician must keep in his mind that complications could develop with a patient; it is reasonable to assume that some patients are not going to do well. T. 1631,1632. There is no indication in the office record for the 20th that the Respondent considered a subphrenic abscess, bleeding or other complications. T. 1639.

94. Petitioner's expert criticized Respondent's plan of treatment that directed the Patient to call Dr. Gavin in three days; he should have been seen the next day even if he had only atelectasis and a 101 degree temperature. T. 661-662.

95. When pressed as to when specifically he felt that he no longer had any legal or medical responsibility for the Patient, the Respondent said he always felt responsible for him. T. 1248.

96. When Dr. Eberle stated that there would not be a need to take immediate action after the office visit of April 20, it was based on the assumption that Respondent had done an evaluation that indicated only slight tenderness to palpation predominantly in the upper right quadrant. T. 660-661.

97. Following the conclusion of cross-examination of Dr. Eberle, he stated that it was still his opinion that he agreed with the criticisms of Respondent's care and records in paragraphs C.3 and C.4 of the Statement of Charges. T. 682-683.

98. Dr. Eberle stated the Respondent's post-operative and office notes for Patient C were inadequate. T. 682; Ex. 12.

D. PATIENT D.

99. Patient D was a 9 year old girl when she was admitted to Albany Memoprial Hospital on December 6,1985. Ex. 14, p.1.

100. Patient D was admitted with abdomenal pain and fever; she was diagnosed by Respondent as having appendicitis,; on the date of admission, her appendix was removed. T. 704; Ex. 14, pp. 5, 20. Patient D was discharged on December 13, 1985, one week after the operation. T. 704.

101. During her hospitalization, Patient D's white blood count increased from 9,300 to 14,400 between December 11th to 13th, and the Patient's temperature was almost consistently elevated above normal. Ex 14, Ex. 14, opp. 26, 44-45. Respondent noted these temperature elevations as well as white blood count elevation. T. 707; Exs 14,15.

102. Patient D's white blood count is of concern because the total white blood count is increasing whereas with Patient C the

immature cells were increasing; either one raises concern. T. 722-723.

103. Petitioner's expert stated Respondent's discharge of Patient D on December 13, 1985 did not meet acceptable standards of medical care because the Patient had a gangrenous appendix with a positive culture, had a persistently elevated temperature, and had an elevated white blood count that was actually increasing at discharge rather than decreasing. Respondent had not established the reason after a week in the hospital. T. 709.

104. Respondent should have, but did not, perform a rectal examination before discharge of the Patient. A rectal would be one of the first examinations if one is considering a possibility of a complication following removal of a gangrenous appendix with positive cultures. T. 709. A rectal examination would be important as the pelvis is an area of frequent localization of persistent infection and abscess after this procedure. T.710. A rectal examination after a week post-operatively could show some induration, or tenderness, or a mass. T. 711.

105. Petitioner's expert witness stated a prudent physician would not discharge the Patient without performing a rectal examination as no adequate answer had been found for the sustained fever and increasing white counts which indicate a brewing infection. T.719. Such is the case even though there was an ability to follow Patient D as an outpatient. T. 718-719.

106. Petitioner's expert stated it would have been acceptable to discharge the Patient if she had been assessed before hand to assure that there was a focus of infection, including the performance of a rectal examination. T. 725,1659,1675,1661-1662.

107. Petitioner's expert stated that no reasonably prudent physician would defer the rectal examination of Patient D to be performed on an outpatient basis. T. 730.

108. While it is true that the abscess this Patient developed was according to Respondent's later operative report to drain the abscess, out of reach of the probing finger, Respondent stated that the most likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum. T. 1314, 1328.

108. While it is true that Respondent stated in a later operative report to drain the abscess that it was out of reach of a probing finger, Respondent stated on questioning that the most likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum. T. 1314, 1328.

109. Respondent attributed the Patient's continued fever in the hospital to a viral infection, but he did not note viral infection anywhere in the hospital record, even in his listing of diagnoses. T. 1319. Respondent also stated that it was conjecture as to whether a blood count of 30,300 was evidence of viral enteritis. T. 1319, 1330.

110. Dr. Saltzstein, stated that Respondent's hospital records do not reflect any indication why the Patient may be having problems post-operatively. T. 1659. Respondent's expert would have done diagnostic studies such as a rectal exam to try and determine the cause of the problems before discharge. T. 1661-1662.

111. The Respondent's expert would not rely on a plain x-ray to rule out an abscess; he would have tried to find an intraabdominal abscess with other studies. T. 1675.

112. There is no indication in the record that the Respondent wanted to perform a rectal examination but the Patient or family refused to permit it. T. 1667.

E. PATIENT E.

113. Patient E was a 70 year old female when she was admitted to Albany Memorial Hospital on January 13, 1986 for an intestinal obstruction. T. 744; Ex. 15, p. 1.

114. A barium enema revealed that Patient E's obstruction was a lesion tumor of the proximal sigmoid colon. T. 744.

115. The Patient had a carcinoma which grew circumferentially around the bowel, closing down until there was only a relatively small opening. The obstruction was at the end of the decending colon and the beginning of the sigmoid colon, which ends at the rectuim. T. 1342. Surgical removal of the tumor was planned. T. 1343.

116. To prepare Patient E's bowel for surgery, Respondent wanted to have it as clean as possible so that there would be minimum contamination. T. 1344. Due to the obstruction they could not give her a large amount of saline material from above so they tried primarily with saline enemas and antibiotic. T. 1345. The saline enema orders of Respondent were an effort to mechanically cleanse much of the stool and bacteria containing material in the colon, to remove that which was below the obstruction and also to some extent, to go above it and wash down as much as possible. T. 1346; Ex. 15, p. 42.

117. Respondent stated the preparation prior to the procedure was not the best that could be given because the Patient had a partial bowel obstruction. Without the obstruction, there could have been a more thorough cleansing of the bowel. T. 1348.

118. During the surgical procedure on January 16, Respondent removed the portion of the colon that contained the obstructing lesion. Ex. 15, p. 168. He then reattached the bowel by an end-to-end reanastamosis. T. 749; Ex. 15, p. 168.

119. Respondent then created a colostomy by bringing out a loop of right transverse colon, opened it on the table, then stapled shut the top of the distal portion of colon, which contained the anastamosis. T. 749-750. He used a suction tube in the proximal end of the colon and evacuated a large volume of liquid feculent material. T. 749; Ex. 15, p. 168.

120. Dr. Saltzstein, the Respondent's expert, reviewed the preoperative preparation for surgery of Patient E by the Respondent, oral neomycin, rectal saline enemas until clear, some systemic antibiotics. Ex. 15, p. 42. He stated the preparation was the best that could be done under the circumstances. T. 1680. The Respondent gave as good a preoperation preparation with antibiotics and cleansing as could be done. T. 1696.

121. Beginning a few days after surgery, a series of x-rays over many days demonstrated that the Patient had a persistent small bowel obstruction. T. 753-755; Ex. 15, pp. 152-160.

122. While the Patient had such small bowel obstruction, Respondent ordered, and the Patient was fed, Vivonex by a tube that entered her stomach or small bowel. Ex. 15, p. 52-53, 84-86. Vivonex is an elemental nutrient. T. 758. The Patient could not tolerate Vivonex without suction. T. 1358.

123. A barium enema performed on January 29, 1986 revealed an extra-colonic barium collection at the site of the sigmoid anastomosis, indicating that there was a leak at the anastomosis. T. 759-760.

124. A second procedure was performed on Patient E on January 31, 1986 in which adhesions were lysed, multiple resections were performed on the bowel, and the colonic anastomosis was revised. Ex. 15, p. 177-178.

125. Respondent reviewed the January 31st operation stating that there were adhesions throughout the entire abdominal cavity. T. 1374.

126. During the Respondent's testimony about the second procedure, he did not provide the details of the revision of the colonic anastomosis. T. 1374-1376. Respondent's expert implied that the description of the revision of the anastomosis was not complete, and he confirms that the required revision of the anastomosis is not explicitly described. T. 1690; Ex. 15, p. 177.

127. The Respondent specifies the dense site of many adhesions, and the probable obstruction, was at the previous colon anastomatic site; and, multiple adhesions between small intestine and abdominal wall between the adjacent loops were lysed. Multiple resections were performed and anastomosed functionally. The adhesions were secondary to very dense. The bowel injuries and entry in several sections and the resection and functional anastomoses end-on-end with a staple machine are mentioned. The operative report, in general, does comment on the most important elements of complications of surgery that had to be faced. The location of each adhesion, the specific resections performed, the location of the extra-colonic barium may represent ideal notations, but the entries made do note the complexities of the surgery performed. They are minimally adequate. T. 760-761, 1689-1690; Ex. 17, p. 177.

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

A. *Patient A*

The Hearing Committee concludes that Respondent treated the 85 year old female Patient A at his office in June and admitted her to Samaritan Hospital, Troy, New York on July 7, 1983. On July 8, 1983, the Respondent performed surgery on the Patient to repair her ventral hernia, inadvertently lacerating the Patient's small bowel. Findings 5, 6, 7.

A.1. The Petitioner alleges the Respondent inappropriately discharged the Patient from the hospital on July 9th when she was both febrile and had vomited twice that day and her bowel had been lacerated during surgery. The Respondent stated the Patient's temperature had dropped, that her first vomiting of about 350 cc's. of brown fluid was due to a gag reflex from the naso-gastric tube, and that the second vomiting of about 150 cc's of undigested food shortly before discharge at about 6:00 p.m. was due to over eating Findings 10, 15.

Respondent agreed that discharge criteria for Patient A would include eating, drinking and keeping it down. Finding 8. Respondent's videotape includes the three criteria noted along with the moving of the bowel and being afebrile. Findings 24, 26. The Patient's first vomiting episode on the day of discharge took place after 7:00 a.m.; the tube was removed at 6:30 a.m. Finding 21. The Patient's first vomiting did not contain food despite Respondent's attribution of it to her having just ate. Findings 20, 25. Finally, Respondent attributed the second vomiting to undigested food because Patient A could not accommodate her normal eating and drinking habits. Finding 16.

Dr. Saltzstein, the Respondent's expert witness, stated that, if the Patient continued to vomit after being fed, the Patient needs to be evaluated for the reasons why. Vomiting can be a response to a lot of things, including problems with the gastro-intestinal tract. Finding 27.

The temperature of Patient A at 4:00 p.m. prior to the 7:00 p.m. discharge on July 9 was 98 degrees. On the same day, temperatures were 102.1 at noon and 101.4 at 8:00 a.m. It cannot be concluded the temperature remained afebrile at the time of discharge. Finding 9.

During the first procedure a small bowel laceration changed the surgery from a hernia repair alone to one of a ventral hernia and lacerated small bowel repair with possible bowel contamination being added to a possible leak from the hernia repair. Finding 11. The Respondent stated that a patient with a bowel laceration during surgery with fever, nausea and vomiting 24 to 36 hours after surgery could have an intestinal obstruction. Finding 22. Patient A had a fever 24 hours after surgery and vomiting during the period noted by the Respondent. Findings 6, 9 Respondent and Dr. Saltzstein both concluded that problems with the gastro-intestinal tract should have been considered.

The Respondent's criteria for discharge were eating, drinking and keeping it down. Finding 8. They were not met on the day of discharge.

The Hearing Committee confirms Petitioner's expert judgement that Patient A was not stable at the time of discharge. and that the discharge did not meet acceptable medical standards. Findings 12, 13, 14. A prudent physician would have considered the many causes other than the atelectasis chosen by the Respondent as an explanation of the fever. Findings 17, 18. A prudent physician would have watched the Patient's temperature for a period of time before reaching the conclusion of the Respondent. Finding 19. The expert witness of the Respondent, Dr. Saltzstein, confirms that discharge of Patient A on July 9th

was inappropriate in that he was concerned about the fever and vomiting. Findings 23, 27.

The Hearing Committee unanimously concludes that *Allegation A-1. is Sustained.*

A.2. The Petitioner alleges the Respondent inadequately evaluated and treated Patient A after discharge from Samaritan Hospital because he did not perform an adequate office physical examination and did not properly respond to reports of Patient's vomiting, inability to keep liquids or solids down, and severe pain. No formal reply was entered.

On July 11, two days after discharge from the hospital, Patient A was taken to Respondent's office. She was in a lot of pain and vomiting. No temperature, blood pressure or pulse was taken and Respondent did not use a stethoscope or touch Patients abdomen. Finding 28. An adequate physical exam was not given by the Respondent. Temperature, pulse and respiration should have been recorded; the chest, lungs and abdomen palpated and auscultated (feeling and listening) and a lung and chest examination should have been completed. Dr. Saltzstein agreed the a palpation of the abdomen was indicated. Findings 28, 29.

The next day, two of Patient A's sons separately called the Respondent reporting a lot of pain. An appropriate response would have been to see the Patient that day and adequately examine her. Findings 30, 31.

Respondent stated that in response to multiple calls he recommended the Patient be walked. The number of calls were more than for the average patient, more than three or four calls per day. Findings 32, 39.

At about 9:00 p.m. the same day, a son called the Respondent to tell him something had to be done about the pain. The Respondent replied the Patient could do anything except drive a car, that nothing was wrong with the Patient. Respondent was told the Patient could not even get out of bed. Respondent insisted so she could get rid of gas and recommended Mylanta.

Finding 33. Petitioner expert stated the response was not adequate and the Respondent should have seen the Patient that day. Finding 34.

Later that night, at about 3:00 a.m. on July 13th Patient's step-daughter called the Respondent and told him Patient A was crying in pain, was really bad off. Respondent gave her an appointment to see him at 8:30 a.m. Finding 35. Given the symptoms, Respondent should have seen the patient as soon as possible. The five and one-half hour delay before appointment was not acceptable, particularly considering the short times between the calls. Again Respondent's response to the information did not meet acceptable medical standards. Finding 36.

Within a few hours after the 3:00 a.m. call to the Respondent on July 13th, Patient A collapsed, was taken to hospital by ambulance, and died. Finding 37

Respondent was told the Patient was vomiting small amounts of food continuously after she ate and drank. He attributed it to her consuming large amounts of food and being obese whereas she was only swallowing tea and toast. Finding 38.

When presented with the facts Respondent testified to, Dr. Saltzstein stated he would want to evaluate the Patient personally, at her home or in the hospital. Finding 40.

The Hearing Committee unanimously concludes that *Allegation A.2 is Sustained.*

A.3. The Petitioner alleges that Respondent's post-operative hospital and office notes for Patient A are inadequate. No formal reply was entered.

Adequate physician notes are important to indicate the thought processes of the physician at the time of treatment. Another physician taking over care can determine what the thoughts of the treating physician were. Finding 42. Respondent's expert Dr. Eberle stated that Respondent's second hospital progress note for July 9, 1983 was not adequate. Finding 41.

Dr. Saltzstein stated he would like to see the findings of vomiting and fever recorded as well as an explanation of why the Patient was discharged. Finding 44. Objectively meaningful medical information for other practitioners is required. Finding 45.

Respondent's office record does not contain an adequate post-operative record of Patient A Acceptable medical standards must reflect the examination performed. None of the vital signs are recorded. Finding 43.

The Hearing Committee unanimously concludes that *Allegation A.3 is Sustained.*

B. *Patient B*

The Committee concludes that the Respondent treated Patient B, a 47 year old male, at Albany Memorial Hospital in Albany, New York, and at Respondent's office in October and November, 1983. Respondent performed a cholecystectomy on Patient B on October 3, 1983, at Albany Memorial Hospital. Findings 46, 48.

B.1. The Petitioner alleges the Respondent inappropriately discharged Patient B from the Hospital on October 4, 1983, when his vital signs had not sufficiently returned to normal following a difficult cholecystectomy. No formal reply was entered.

During the surgery, dissection of the gall bladder was difficult Finding 47. Patient B was discharged the following day, October 4, 1983 at about 6:30 p.m. Finding 48.

The last temperature reading before discharge was 100.2 (oral) degrees at 4:00 p.m. At 4:00 p.m. Patient B's pulse was 90; his respirations, 30. Finding 49.

Dr. Saltzstein confirmed the vital signs of Patient B were consistent with a reasonable medical decision to discharge him

on October 4th. There was a normal progression of recovery in progress. Finding 50.

The Hearing Committee unanimously concludes that *Allegation B.1 is Not Sustained.*

B.2. The Petitioner alleges the Respondent inadequately evaluated and treated Patient B after discharge from Albany Memorial Hospital because he did not perform an adequate physical examination at his office and did not properly respond to reports of patient pallor, jaundice, soaking sweat, and severe pain. No formal reply was entered.

The day after discharge from the hospital, the wife of Patient B told the Respondent that he was pale, with a yellowish tinge. Finding 55. She again called the Respondent after the first post-hospital office visit and before the next visit on October 9 to report that her husband's color was bad. Finding 58. She was not a trained medical observer. The Respondent had seen and evaluated the Patient twice. Jaundice and pallor were not established by a preponderance of the evidence to the satisfaction of the entire Hearing Committee. Finding 55.

Soaking sweat was characteristic of Patient B's physical condition prior to the October 9 visit. Finding 56. Severe pain, a profuse sweat and feeling cold and clammy were reported to the Respondent on October 9. Finding 57. 58. The Respondent directed Patient B's wife to bring the Patient to his office within the hour Finding 58.

Following the visit, the Respondent reported to the Patient's son who was in the waiting room during the visit that everything was going pretty good, right on schedule. Finding 59.

The Respondent's expert, Dr. Saltzman, reported he was not able to determine what was done or not done from the Respondent's office notes, including the absence of an evaluation of the Patient. The Petitioner's expert, Dr. Eberle, reported the same conclusions, itemizing what should be in the office notes of the October 9th visit. Findings 60, 61.

The Hearing Committee unanimously concludes that a preponderance of evidence has not been established to affirm the allegation.

Allegation B.2 is Not Sustained.

B.3 The Petitioner alleges the Respondent's post-operative hospital and office notes for Patient B are inadequate. Respondent admitted his post-operative hospital and office notes are inadequate, but he believes that 1984 standards were met. Finding 54. The Committee has adopted the standards set forth in *Schwartz v. Board of Regents*, requiring in 1982 that objectively meaningful medical information be the standard of adequacy for medical records. See, Significant Legal Rulings, *supra,* p. 8.

Respondent's expert, Dr. Saltzstein, stated the records do not indicate what the Respondent did or did not do and do not contain an evaluation of the Patient. Finding 60. Dr. Eberle, Petitioner's expert, states the Respondent did not take an adequate history and did not perform an adequate physical exam. He summarized by stating that the Respondent's office records do not meet acceptable standards of medical record keeping. Findings 61, 62.

The Hearing Committee unanimously concludes that *Allegation B.3 is Sustained.*

C. *Patient C.*

The Committee concludes the Respondent treated Patient C, a 53 year old male, at Samaritan Hospital, and at Respondent's office on or about April, 1984. Respondent performed a cholecystectomy on Patient C on April 13, 1984 at Samaritan Hospital. Finding 63.

C.1. Allegation was withdrawn.

C.2. The Petitioner alleges Respondent inappropriately discharged Patient C from the hospital on April 14, 1984, because the patient's abdomen was distended, he had not moved his bowels adequately, he did not wish to be discharged until he had adequate bowel movement, his red blood cell count, hemoglobin and hematocrit were declining, and he had a white blood cell count of 12,500 with polys of 81, stabs of 9. No formal reply was entered.

Patient C was admitted to Samaritan Hospital on April 13, 1984. He was diagnosed as having acute cholecystitis, and a cholecystectomy was performed the same day by the Respondent. The pathology report found the Patient had acute suppurative cholecystitis with focal necrosis and much hemorrhage. Finding 63.

Patient C was discharged at 7:30 p.m. on April 14th. The predischarge blood counts of the Patient are consistent with post-surgery inflammation. The Respondent's expert, Dr. Saltzstein, stated that waiting for a bowel movement is not a reason to keep a patient in a hospital; evidence of gastrointestinal function, tolerating liquids, is adequate. Findings 64, 65, 66, 67.

The Hearing Committee unanimously concludes that *Allegation C.2 is Not Sustained.*

C.3 The Petitioner alleges the Respondent inadequately evaluated and treated Patient C after discharge from Samaritan Hospital because he did not perform an adequate physical examination at his office, he did not properly respond to reports of patient fever, hiccoughs, vomiting, difficulty in keeping solids down, abdominal distension, and severe pain. No formal reply was entered.

The Respondent saw Patient C at his office on April 15, looked at the abdomen, touched around the incision area, but did not take the Patient's vital signs. Finding 69. On April 16th Respondent was called and told Patient C was in pain in his side

around the right arm; Respondent stated such was expected. On April 17th, respondent was called to report the Patient had pain further down his right side and was not eating properly. The Respondent's reply was that such was expected and he would see the Patient the next day at the scheduled visit. Finding 71. The Petitioner's expert witness, Dr. Eberle, stated that with the complaints of pain, the Respondent should have seen the Patient earlier that the scheduled appointment. Finding 72.

At the April 18th office visit, the Respondent was told the Patient was not feeling well, had a pain in his right side, had hiccoughs, was only eating jello and a little toast, was not sleeping well, felt bloated, and could not go to the bathroom. Respondent gave Maalox and indicated the complaints went along with the surgery. He did not take vital signs. Finding 73. Dr. Eberle stated the Respondent did not adequately Patient C on April 18th. The chest and abdomen should have been examined. With hiccoughs, there would be concern about diaphragmatic irritation. Finding 74.

Respondent's examinations on April 15th and 18th consisted of observing the Patient walking and breathing, touching his hand to feel the pulse, noting his general appearance, examining the wound, and applying general pressure to see if there was tenderness. Absent were examinations of the abdomen and chest that Dr. Eberle stated should have been performed. Finding 75

Early on April 20th, a call to the Respondent informed him that the Patient was vomiting, had a fever, tried to go the the bathroom and couldn't, felt he had gas but could not relieve it. Respondent said the Patient should be brought to his office at 8:00 a.m. Finding 76. Respondent recalls the complaints were of fever and pain in the lower part of the right chest when he took a breath. Finding 77.

At the office visit on April 20th, the Patient complained of severe pain at the right rib margin when he took a deep breath and again repeated the symptoms reported a few hours earlier on

the phone. Finding 79. Respondent diagnosed the Patient had atelectasis. Finding 80.

Two chest x-rays were taken. One demonstrates the Patient's right diaphragm is high and there may be some atelectasis and/or interstitial, interlobular effusion. A reasonably prudent surgeon, on viewing the x-ray of a patient who had a cholecystectomy a week earlier, would consider the causes of the elevation of the right diaphragm. They could be atelectasis or something below the diaphragm pushing it up. Finding 81.

Given the information provided to the Respondent and the facts shown in the Respondent's office record, no complete evaluation of the Patient was performed; no findings were made about the Patient's abdomen prior to deciding that the problem was in the chest. Finding 82.

Dr. Saltzstein stated the Patient's x-ray with an elevated right hemi-diaphragm would make one consider the possibility of something happening under the diaphragm. The other x-ray indicates there may be some fluid on the lung; the pleural effusions indicate the possibiity of something going on below the diaphragm. Finding 83. Dr. Eberle stated the diagnosis of atelectasis is unusual the seventh day after surgery. There is no record of an abdominal examination, and the elevated diaphragm is likely to be caused by something below the diaphragm. Finding 84. The Patient's lower chest pain can be caused by something below the elevated diaphragm. Finding 85.

Respondent stated the x-ray would indicate something beneath the diaphragm. Such was rejected because the Patient's complaints related only to respiratory problems in the right chest. There could be a sterile irritating collection even in the absence of fever and signs of inflammation. Finding 86.

Respondent's plan of treatment on the 20th was for the Patient to take Ampicillin, steam, encourage coughing, and call Dr. Gavin in three days if symptoms persist. The plan does not meet acceptable standards of medical care. Finding 88.

Respondent stated he believed an abscess would be premature for Patient C; and, if it were the result of infection, the Patient would have a temperature. On April 20th the office record of the Respondent evidences a one day history of a 101 degree temperature. Respondent also stated there is a 5% incidence of infection after acute cholecystitis. Finding 91.

Respondent agrees that post-operative care is directed at preventing and promptly recognizing and treating complications after cholecystectomy, such as subphrenic abscess. One reason the right diaphragm may be elevated is an abscess. Finding 92.

Dr. Saltzstein agrees that with early patient discharge, a prudent physician knows that complications could develop; some patients are not going to do well. There is no indication in the office record for the 20th that Respondent considered a subphrenic abscess, bleeding or other complications. Finding 93.

Dr. Eberle criticized Respondent's treatment plan that directed the Patient to call Dr. Gavin in three days; even if he only had atelectasis with a 101 degree temperature. Finding 94. The Respondent stated he always felt medical and legal responsibility for Patient C. Finding 95.

Dr. Eberle stated that his original opinion that it was not necessary to take immediate action at the April 20th visit had assumed an evaluation of only slight tenderness to palpation in the upper right quadrant. Finding 96 He agreed with the criticisms of the Respondent's care set forth in Paragraph C.3. Finding 97.

Two physicians who admitted the Patient in the Emergency Room on April 21st noted hiccouoghs. Finding 87.

The Hearing Committee unanimously concludes that *Allegation C.3 is Sustained.*

C.4 The Petitioner alleges the Respondent's post-operative hospital and office notes for Patient C are inadequate. No formal reply was entered.

Respondents post-operative progress note of 4/14/84 does not meet acceptable standards of medical note keeping because it does not address the issues peresented by the contents of the hematology reports and by comments in the nursing notes concerning not having a BM, and a distended abdomen. If the Respondent's note was made prior to the nurse's note, they should have been addressed in a later note. Finding 68

Respondent's notes do not indicate he adequately addressed the complaints of Patient C. Finding 70. Respondent recorded no examination of the chest or of the abdomen. Findings 75,82,84,89.

Respondent's office records for April 20th do not contain adequate information for Dr. Gavin to take over care of the Patient. There is no informaiton about any problems the Patient had earlier than one day before the 20th. Finding 90.

Petitioner's expert testified he agreed with the criticisms of Respondent's records as set forth in paragraph C.4 of the Statement of Charges. Finding 97. Dr. Eberle stated the Respndent's post-operative and office notes for Patient C were inadequate. Finding 98.

The Hearing Committee unanimously concludes that *Allegation C.4 is sustained.*

D. *Patient D*

The Respondent treated Patient D, a 9 year old female, at Albany Memorial Hospital, and at Respondent's office on or around December 1985. Respondent performed an appendectomy on Patient D on or about December 6, 1985 at Albany Memorial Hospital. Findings 99, 100.

D.1 The Petitioner alleges the Respondent inappropriately discharged Patient D from the hospital on December 13, 1985, when the cause of her fever had not been adequately assessed,

she had an elevated blood count, and Respondent had not performed a rectal examination before discharge. No formal reply was entered.

During her hospitalization, Patient D's white blood count increased from 9,300 to 14,400 between December 11th to 13th, and the Patient's temperature was almost consistently elevated above normal. Respondent noted both the temperature and white blood count elevations. Finding 101.

Patients D's white blood count is of concern because both the total and the immature cell count were increasing. Finding 102.

Petitioner's expert, Dr. Eberle, stated the discharge of Patient D on December 13th did not meet acceptable standards of medical care because the Patient had a gangrenous appendix with a positive culture, had a persistently elevated temperature, and had an elevated blood count that was actually increasing at discharge, rather than decreasing. Respondent had not established the reason after a week in the hospital. Finding 103.

Dr. Eberle stated Respondent should have, but did not, perform a rectal exam before the discharge of the Patient. It would be one of the first exams considered in Patient C's type of case where the pelvis is an area of frequent localization of infection and abscess. A week after an operation, a rectal could show some induration, or tenderness, or a mass. A prudent physician would not discharge the Patient without performing a rectal exam because no adequate answer had been found for the sustained fever and increasing white counts indicating a brewing infection even if there was an ability to follow the Patient as an outpatient. Finding 104, 105.

If the Patient had been assessed before hand to assure there was a focus of infection, including the performance of a rectal examination, it would have been acceptable to discharge her. No reasonable physician would defer the rectal examination to be performed on an outpatient basis. Finding 106.

The Respondent's later operative report to drain Patient D's abscess stated it was out of reach of a probing finger. The Respondent also stated the most likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum Finding 108.

Respondent attributed the Patient's continued fever in the hospital to a viral infection. He did not note viral infection anywhere in the hospital record, even in his listing of diagnosis. He also stated it was conjecture as to whether a blood count of 30,300 was evidence of viral enteritis. Finding 109.

Dr. Saltzstein stated that Respondent's hospital records do not reflect any indication why the Patient was having problems post-operatively. Respondent's expert would have done diagnostic studies such as a rectal exam to try to determine the cause of the problems prior to discharge. Finding 110

Dr. Eberle would not rely on a plain x-ray to rule out an abscess; he would have tried to find an intraabdominal abscess with other studies. Finding 111.

There is no indication in the record that the Respondent wanted to perform a rectal examination but the Patient or family refused to permit it. Finding 112.

The Hearing Committee unanimously concludes that *Allegation D.1 is Sustained.*

E. *Patient E*

Respondent treated Patient E, a 70 year old female, at Albany Memorial Hospital from on or about January 13, 1986, through February 2, 1986. Patient E was admitted to Albany Memorial Hospital due to intestinal obstruction and Respondent performed surgery on Patient E on January 16, 1986 and January 31, 1986. Findings 113,118,124; Ex. 15, p. 2.

E.1 The Petitioner alleges pre-operative preparation of the bowel for the operation on or about January 16, 1986 was inadequate. No formal reply was entered.

Patient E was hospitalized for an intestinal obstruction, identified as a lesion tumor of the proximal sigmoid colon. Surgical removal of the tumor was planned. Findings 113, 114,115.

Respondent prepared Patient E for surgery with saline enemas and antibiotic. Without the bowel obstruction there could have been a more thorough cleansing. Findings 116,117.

On January 16, Respondent removed the colon portion containing the lesion and reattached the bowel by an end-to-end reanastamosis, followed by a colostomy created by bringing out a loop of right transverse colon, opening it, stapling shut the top distal portion of the colon containing the anastamosis. A suction tube was used to evacuate a volume of liquid feculent. Findings 118, 119.

Dr. Saltzstein, the Respondent's expert, reviewed the preoperative preparation of oral neomycin, rectal saline enemas until clear, some systemic antibiotics. He stated the preparation was the best that could be done under the circumstances. Finding 120

The Hearing Committee unanimously concludes that *Allegation E.1 is Not Sustained.*

E.2 The Petitioner alleges the Respondent instilled Vivonex into Patient E despite evidence that her small bowel was partially obstructed. No formal reply was entereed.

Several post-surgery x-rays identified a persistent small bowel obstruction. The Respondent ordered feeding with Vivonex through a tube that entered her stomach or small bowel. The Patient could not tolerate Vivonex without suction. Vivonex is an elemental nutrient. Findings 121, 122.

The Hearing Committee, noting that the Vivonex was able to be absorbed in some part before and during the suction process, determined that the bowel obstruction did not obviate its use.

The Hearing Committee unanimously concludes that *Allegation E.2 is Not Sustained.*

E.3 Allegation E-3 was withdrawn.

E.4 The Petitioner alleges the Respondent's operative note for the operation on January 31, 1986, was inadequate because it does not mention the location of the adhesions, the multiple resections of the bowel, the presence of the extra colonic barium collection, and the details of the revision of the colonic anastamosis. No formal reply was entered.

A barium enema on January 29th indicated there was a leak in the anastamosis. A second procedure was performed on January 31st. Adhesions were lysed, multiple resections were performed on the bowel and the colonic anastamosis was revised. The Respondent stated there were adhesions throughout the entire abdominal cavity. Findings 123, 124 125.

The Respondent did not provide details of the revision of the colonic anastamosis. Dr. Saltzstein, Respondent's expert implied the description of the revision was not complete. He confirmed that the required revision of the anastamosis is not explicitly described. Although the Respondent's expert finds the operative report comments on ". . . the most important elements . . ." of the surgery, the location of the adhesions, the resections performed, and the location of the extra-colonic barium are not specified. The Respondent testified concerning all of these. Findings 126, 127.

The Hearing Committee,noting that the testimony of the Respondent substantially fills in the gaps of the operative report, concludes that such was available and should be in the report to

meet the minimum New York standard of objectively meaningful medical informaiton. Significant Legal Rulings, *supra,* p. 8.

The Hearing Committee unanimously concludes that *Allegation E.4 is Sustained.*

CONCLUSIONS WITH REGARD TO SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS:
Practicing with Gross Negligence

FIRST SPECIFICATION: Having sustained allegations A.1, and A.2, the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in both hospital discharge of Patient A on July 9, 1983 and in post-discharge treatment of Patient A thereafter.

SECOND SPECIFICATION: Having failed to sustain allegations B.1 and B.2, the Hearing Committee unanimously concludes that the Respondent did not practice with gross negligence either in hospital discharge of Patient B on October 4, 1983 or in the post-discharge evaluation and treatment of Patient B thereafter.

THIRD SPECIFICATION: Having withdrawn allegation C.1, and having failed to sustain allegation C.2, and having sustained allegation C.3, the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in inadequately evaluating and treating Patient C after hospital discharge on April 14, 1984, but that the hospital discharge was appropriate.

FOURTH SPECIFICATION: Having sustained allegation D.1, the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in hospital discharge of Patient D on December 13, 1985.

FIFTH SPECIFICATION: Having failed to sustain allegations E.1 and E.2 and having withdrawn allegation E.3, the Hearing Committee unanimously concludes that the Respondent did not practice with gross negligence either in pre-operative preparation of Patient C's bowel on or about January 16, 1986 or in instilling Vivonex into Patient C.

SIXTH SPECIFICATION:
Practicing with negligence on more than one occassion

SIXTH SPECIFICATION: Having sustained allegations A.1, A.2, C.3 and D.1 as heretofore set forth, despite having failed to sustain or withdrawn the other negligence allegations cited, the Hearing Committee unanimously concludes that the Respondent practiced with negligence on Patients A, C and D on four occassions.

SEVENTH THROUGH TENTH SPECIFICATIONS
Inadequate medical records
(Note: The First Specification No. 7 repeats Specification No. 6; herein, Specifications numbered "8..9., 10., and 11." have been renumbered to conform to the caption: "7., 8., 9., and 10.")

SEVENTH SPECIFICATION: Having sustained allegation A.3, the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient A being inadequate.

EIGHTH SPECIFICATION: Having sustained allegation B.3, the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient B being inadequate.

NINTH SPECIFICATION: Having sustained allegation C.4, the Hearing Committee uanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient C being inadequate.

TENTH SPECIFICATION: Having sustained allegation E.4, the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his operative note for the operation on January 31, 1986 being inadequate.

CONCLUSIONS WITH REGARD TO RESPONDENT'S CREDIBILITY

An example of the equivocation characteristic of the Respondent is provided in his statements concerning Patient A's two episodes of vomiting on the day of discharge the day after surgery. First it was the naso-gastric tube removal stimulating a gag reflex (Finding 15), then it was due in part to having just eaten (Finding 20). Finally, he acknowledged that 350cc's is a large volume of liquid, that it was brown in color indicating bile, and that there was no indication of food in the vomit. Finding 25. And the 150cc's of vomit somewhat before discharge were the result of not being able to accommodate normal eating and drinking habits. Finding 16.

The Respondent managed to avoid the conclusions of both medical experts that pain and vomiting post-operatively dictated an abdominal examination prior to discharge at the least. Findings 14, 23. More incredulous, verging on the bizarre, is the ability of the Respondent to avoid the application of his own

discharge criteria: eating, drinking, keeping it down. Finding 24. At the least, acceptable standards of medical care were breeched by the Respondent. T. 394; Ex. 5. And Respondent's position on the critical discharge of Patient A demonstrated his capacity to mold facts to fit his view that Patient A cannot be having problems needing resolution prior to discharge.

In response to a question by a member of the Hearing Committee, the Respondent stated he was still in active practice. The Respondent, however, has no surgical privileges at any hospital in the Albany area. He is consultant at Harlem Center Hospital, but was not practicing operative surgery at the time of the hearing. T. 998.

SUMMARY OF CONCLUSIONS

As set forth in Significant Legal Rulings on page 7 the Hearing Committee has applied the following definitions in formulating its conclusions:

> Negligence is a deviation from the acceptable standard of care.
>
> Negligence on more than one occasion is proved by acts of negligence on more than one event of some duration.
>
> Gross negligence is proved by a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct.

The Hearing Committee finds that Respondent placed Patients A, C and D, because of his inappropriate hospital discharge of Patients A and D, and his post-discharge evaluation and treatment of Patients A and C. despite the repetitive reports he received on their condition, at substantial risk. The discharges and lack of treatment of patients after discharge each constitute gross negligence, egregious and multiple.

Respondent's medical records for Patients A, B, C, and E do not meet the mandated requirement of objectively meaningful information. Neither expert witness was able to determine what the Respondent did or did not do related to essential elements of hospital and post-discharge evaluation and treatment. If an expert is not able to determine essential information on both, a physician filling an emergency or succeeding another physician is not able to provide the evaluation and treatment needed with dispatch. The patient records are a lifeline to continuity of care. The testimony of the experts is the best evidence of the records meeting the standard of acceptability.

In essence, the Hearing Committee has grave misgivings about the continuation of surgical practice by the Respondent. His apparent efforts to embellish the results of early discharge of patients to their detriment, his lack of remorse or insight into his problems, and his denial of wrongdoing despite the candid testimony of objective experts representing the Petitioner and the Respondent largely contribute to the Committee's conclusions. The Respondent's inability to focus on the questions and to answer them directly contributed to the conclusions as well.

ORDER

IT IS HEREBY ORDERED that the license number 087923 issued by the New York State Education Department to GERALD MOSS, M.D. be and hereby is limited to the area and type of practice of consultation to the exclusion of all other types of medical practice.

DATED: Syracuse, New York
March 24, 1993

BY: s/Joseph K. Myers, Jr.
JOSEPH K. MYERS, JR., M.D., F.A.C.S.

ROBERT A. MENOTTI, M.D., F.A.C.S.

GEORGE F. COUPERTHWAIT

APPENDICES

Appendix I. Statement of Charges (with ammendments noted)

Appendix II. Ruling on Bias Request

Appendix III. Petitioner's Motion to Instruct the Hearing Committee Not to Consider Pages 74 through 78 of Respondent's Proposed Findings; Administrative Officer's Notice re the Subject Hearing

Appendix IV. Affidavit of Respondent's Expert Witness in Lieu of Rejected Conclusory Statement at the

Hearing, submitted for the record only, Denied by the Administrative Officer

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

STATEMENT OF CHARGES

GERALD MOSS, M.D., the Respondent, was authorized to practice medicine in New York State on July 20, 1962, by the issuance of license number 087923 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991, through December 31, 1992, with a registered address of Climer Circle, Box 296, West Sand Lake, New York 12196.

FACTUAL ALLEGATIONS

A. The Respondent treated Patient A (patients are identified in Appendix A), an 85 year old female, at Samaritan Hospital in Troy, New York, (hereinafter Samaritan Hospital) and at his office at RD 1, Rensselaer, New York, during June and July 1983. On or about July 8, 1983, Respondent performed surgery on Patient A at Samaritan Hospital to repair a ventral hernia.

1. The Respondent inappropriately discharged Patient A from the hospital on July 9, 1983, when she was febrile that day, she had vomited twice that day, and her bowel had been lacerated during surgery.

2. The Respondent inadequately evaluated and treated Patient A after discharge from Samaritan Hospital because he did not perform an adequate physical examination at his office and he did not properly respond to reports of patient vomiting, inability to keep liquids or solids down, and severe pain.

3. Respondent's [operative] [and] post-operative hospital and office notes for Patient A are inadequate.

B. Respondent treated Patient B, a 47 year old male, at Albany Memorial Hospital in Albany, New York, and at Respondent's office on or about October and November 1983. Respondent performed a cholecystectomy on Patient B on or about October 3, 1983, at Albany Memorial Hospital.

1. The Respondent inappropriately discharged Patient B from the hospital on October 4, 1983, when his vital signs had not sufficiently returned to normal following a difficult cholecystectomy.

2. The Respondent inadequately evaluated and treated Patient B after discharge from Albany Memorial Hospital because he did not perform an adequate physical examination at his office and he did not properly respond to reports of patient pallor, jaundice, soaking sweat, and severe pain.

3. Respondent's post-operative hospital and office notes for Patient B are inadequate.

C. The Respondent treated Patient C, a 53 year old male, at Samaritan Hospital, and at Respondent's office on or about April 1984. Respondent performed a cholecystectomy on Patient C on or about April 13, 1984 at Samaritan Hospital.

1. During the surgery Respondent placed a surgical drain in the patient, but Respondent did not leave the drain in Patient C for a sufficient period of time post-operatively.

2. The Respondent inappropriately discharged Patient C from the hospital on April 14, 1984, because the patient's abdomen was distended, he had not moved his bowels adequately, he did not wish to be discharged until he had adequate bowel movement, his red blood cell count, hemoglobin and hematocrit were declining, and he had a white blood cell count of 12,500 polys of 81, stabs of 9.

3. The Respondent inadequately evaluated and treated Patient C after discharge from Samaritan Hospital because he did not perform an adequate physical examination at his office, he did not properly respond to reports of patient fever, hiccoughs, vomiting, difficulty in keeping solids down, abdominal distension, and severe pain.

4. Respondent's post-operative hospital and office notes for Patient C are inadequate.

D. The Respondent treated Patient D, a 9 year old female, at Albany Memorial Hospital, and at Respondent's office on or around December 1985. Respondent performed an appendectomy on Patient D on or about December 6, 1985 at Albany Memorial Hospital.

1. The Respondent inappropriately discharged Patient D from the hospital on December 13, 1985, when the cause of her fever had not been adequately assessed, she had an elevated white blood count, and Respondent had not performed a rectal examination before discharge.

E. Respondent treated Patient E, a 70 year old female at Albany Memorial Hospital, from on or about January 13, 1986, through February 2, 1986. Patient E was admitted to Albany Memorial Hospital due to intestinal obstruction and Respondent performed surgery on Patient E on January 16, 1986, and January 31, 1986.

1. Pre-operative preparation of the bowel for the operation on or about January 16, 1986, was inadequate.

2. Respondent instilled Vivonex into Patient E despite evidence that her small bowel was partially obstructed.

3. Respondent improperly performed multiple resections and anastamoses on Patient E on January 31, 1986.

4. Respondent's operative note for the operation on January 31, 1986, was inadequate because it does not mention the location of the adhesions, the multiple resections of the bowel, the presence of the extra colonic barium collection, and the details of the revision of the colonic anastamosis.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS
PRACTICING WITH GROSS NEGLIGENCE

The Respondent is charged with practicing the profession of medicine with gross negligence under N.Y. Educ. Law §6530 (4) (McKinney Supp. 1992) [formerly N.Y. Educ. Law] §6509 (2) (McKinney 1985)] in that the Petitioner charges:

1. The facts in paragraphs A and A.1, and/or A and A.2.

2. The facts in paragraphs B and B.1, and/or B and B.2.

3. The facts in paragraphs C and C.1, C and C.2, and/or C and C.3

4. The facts in paragraphs D and D.1.

5. The facts in paragraphs E and E.1, E and E.2, and/or E and E.3.

SIXTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530 (3) (McKinney Supp. 1992) [formerly N.Y. Educ. Law §6509 (2) (McKinney 1985)] in that the Petitioner charges that the Respondent committed two or more of the following:

6. The facts in paragraphs A and A.1, A and A.2, B and B.1, B and B.2, C and C.1, C and C.2, C and C.3, D and D.1, E and E.1, E and E.2, and/or E and E.3.

SEVENTH THROUGH TENTH SPECIFICATIONS

INADEQUATE MEDICAL RECORDS

The Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient under N.Y. Educ. Law §6530 (32) (McKinney Supp. 1992) [formerly §6509 (9) (McKinney 1985) and 8 NYCRR §29.2 (a) (3) (1989)] in that the Petitioner charges:

7. The facts in paragraphs A and A.3.

8. The facts in paragraphs B and B.3.

9. The facts in paragraphs C and C.4.

10. The facts in paragraphs E and E.4.

DATED: Albany, New York
August 5, 1992

s/Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF

GERALD MOSS, M.D.,

Respondent.

RULING ON BIAS REQUEST

New York State Department of Health rules specify that a hearing officer shall conduct a hearing in a fair and impartial manner. 10 NYCRR 51.9 (b). Further, the Rules set forth the requirements for a disqualification for bias. Pertinent provisions are that bias exists where there is a "substantial liklyhood" the outcome of a case will be affected by a person's prior acquaintance with a witness. The appearance of impropriety does not constitute bias and is not grounds for disqualification. Hearing committee members are presumed to be free from bias; the burden of demonstrating bias is on the proponent. 10 NYCRR 51.17.

The Administrative Officer concludes that the test to be applied is whether a reasonable disinterested observer knowing all the facts and circumstances presented concerning allegations of partiality would question a committee member's impartiality. Apprehensions of parties are not relevant to the determination. A mere allegation of bias will not suffice. *Warder v. Board of Regents*, 53 NY 2d 186 (1981).

BACKGROUND

The Administrative Officer was informed on August 11, 1992 shortly prior to the scheduling of the Pre-Hearing Conference that was attended by the Administrative Officer and the two attorneys for the parties that the Chairperson of the Hearing Committee, Dr. Joseph K. Myers, Jr., and an expert witness had been on the medical staff of the same hospital. The two attorneys were informed on August 12, 1992.

At the August 19, 1992 Pre-Hearing Conference, the Petitioner's attorney stated Dr. Eberle would be the expert witness for the Petitioner regardless of whether Dr. Myers was a member of the Hearing Committee. PHC S.M. 64.* The attorney of the Respondent expressed his concerns on a potential bias by Dr. Myers. PHC S.M. 66-70. On August 28, 1992, the initial day of the Hearing, the attorney for the Respondent explored the relationship of Dr. Myers and Dr. Eberle reviewed below. Following adjournment, an Intrahearing Conference that was attended by the Administrative Officer, the two attorneys and the Respondent included a review by the Respondent's attorney of his position on whether to file an affidavit required to pursue the matter and references to the Rule of the Department on the matter. 10 NYCRR 51.17; IHC S.M. 13-20.*

THE AFFIDAVITS

The Respondent submitted an affidavit dated September 10, 1992 to the Administrative Officer requesting that Dr. Myers ". . . be replaced by a Hearing Officer who does not know and

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*PHC S.M. ___, IHC S.M. ___ and S.M. ___ refer to page numbers of transcripts of the pre-hearing conference, the intrahearing conference and the full hearing on the matter respectively.

who has no prior knowledge of Petitioner's expert (witness)." A copy is annexed as Attachment I. The Petitioner submitted an affidavit dated October 2, 1992 to the Administrative Officer in opposition to the request. A copy is annexed as Attachment II. The two covering letters speaking to whether the affidavits are addressed to the disqualification of the Petitioner's expert witness are Attachmenmt III.

The affidavit of the Petitioner is a State Administrative Procedure Act, Section 303, request for disqualification for bias. The Administrative Officer for the subject hearing has the authority and the responsibility to rule on all motions and other legal objections including requests for disqualification. Public Health Law, Section 230, subd. 10 (e); 10 NYCRR 51.17 (c).

FACTUAL ALLEGATIONS AND DETERMINATIONS

1. The facts cited by the Respondent are that Dr. Myers is a member of the Hearing Committee, has knowledge of Petitioner's expert witness Dr. Eberle, that both worked in the same hospital, and that such presents a ". . . likely impact" on the weight that will be given by Dr. Myers to Dr. Eberle's testimony. Resp's Affidavit, pars.2, 3.

2. The facts cited by the Petitioner are that Dr. Myers stated that he saw Dr. Eberle perhaps once every two or three weeks passing in the hall of the hospital. They have no financial dealings, do not share practices, do not send patients back or forth, and have no social relationship. Dr. Myers stated he does not know whether Dr. Eberle was a good or bad surgeon, his acquaintanceship would not prejudice a fair judgement, and he has no preconceived notions on how reliable an expert Dr. Eberle may be. S.M. 13-18.

3. The Administrative Officer determined from Dr. Myers that the hospital in which the two physicians have staff privileges is Crouse-Irving Memorial Hospital, 736 Irving Avenue, Syracuse, NY with 557 certified beds listed on the current two year operating certificate commencing August 1, 1992. Attachment IV. Upon information and belief, the hospital currently operates 566 acute care beds with an active medical staff of 569 doctors. October 19, 1992 telecon with Office of Executive Vice-President Marilyn Baader.

4. The Administrative Officer has generally reviewed with Dr. Myers the standards governing disqualification for bias, and the interests served by such disqualification including the basic one of assuring impartiality and the appearance of impartiality. An opportunity was afforded to Dr. Myers to recuse himself should there be any doubt in his mind. October 18, 1992 Telephone Conference.

5. In response to a series of questions by Respondent's attorney on August 28, 1992, Dr. Myers stated:

(a) He had no intimate knowledge of Dr. Eberle's practice. He doesn't know whether Dr. Eberle was a good or bad surgeon and he has been mostly retired for several years. Dr. Myers does not believe there is any possible predjudice that would be involved. S.M. 15.

(b) Dr. Myers has no preconceived opinion of Dr. Eberle's testimony or evaluation of any medical matter. S.M. 15.

(c) In response to a question predicated on Respondent's Counsel stating he was ". . . not saying it's a question of bias, I'm saying it's a question of perhaps unforseeable impact on what I (Respondent's Counsel) would not nesessarily know . . .", Dr.

Myers stated he was acquainted with Dr. Eberle ". . . like I'm acquainted with a lot of physicians." Dr. Myers has no preconceived notions about whether Dr. Eberle is more reliable than an expert witness of the Respondent. S.M. 16-17.

(d) In response to the question of whether Dr. Myers has an opinion one way or the other, on whether Dr. Eberle is a good, bad, competent, incompetent doctor; a good, bad surgeon, Dr. Myers stated his opinion is that Dr. Eberle is a competent physician until proven otherwise. He has never seen any proof to the contrary, but he was never familiar with the tenor of his practice so he could not pass judgement on the practice. Dr. Myers is aware that Dr. Eberle is a surgeon and probably board certified and a member of the American College of Surgeons and he serves on a committee with him but such is not relevant to whether he is biased or not. S.M. 18-19; See Nos. 2, 5 (a) above.

(e) A copy of the August 28, 1992 colloquy relating to the bias issue, S.M. 13-20, is an attachment hereto. See, Attachment V.

CONCLUSIONS

It is concluded that Dr. Myers had knowledge of Dr. Eberle, the Petitioner's expert witness, and both are on the medical staff of Crouse-Irving Memorial Hospital, Syracuse, New York. FAD 1.*

It is further concluded that Drs. Myers and Eberle had and have no social or personal relationships, and no professional

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*FAD ___ refers to the paragraph number of the Section of this Ruling denoted: "FACTUAL ALLEGATIONS AND DETERMINATIONS."

relationships other than being members of the medical staff of a sizable urban hospital with over 500 other physicians and of being members of a committee. FAD 1, 2, 3, 5 (a), (d).

The hospital in question is a sizable upstate general medical facility with over 550 acute care beds and an active medical staff of 569 doctors. Such is a large medical community whose size cannot support an inferrence that medical staff members have opinions on the medical competence of a sizable number of the staff. With nothing more than the facts of membership on the staff and a committee, no liklyhood of any prior bias can be concluded. FAD 3.

Respondent's Counsel has not described the acquaintance between Drs. Myers and Eberle as other than staff membership activities leading to a likely impact on the weight given by Dr. Myers to Dr. Eberle's testimony. The specific statements of Dr. Myers direct one to an opposite conclusion: He has no opinion on the reliability of the expert witness without judging the testimony itself; there is no liklyhood that the staff membership would have any impact on the decisions made. The Administrative Officer concurs.

The remaining question is whether the facts alleged would lead a disinterested person to question the partiality of Dr. Myers. If the hospital whose staff membership is at the core of the issue were a single small facility where the nexus of a physician's practice is centered, where a physician would by necessity work closely with the great majority of fellow staff members, a positive response to the question would have been supported by the candid review of the professional relationship between the two Doctors provided by Dr. Myers. But when a hospital is a large metropolitan facility, the liklyhood of the partiality of a staff member based exclusively on such membership decreases algebraically. Reason, and the facts provided by Dr. Myers, support the conclusion that a disinterested observor would not infer a liklyhood of bias.

DETERMINATION

It is determined that the facts presented do not meet the substantial liklyhood threashold of bias required for the disqualification of Dr. Myers as a member of the Hearing Committee.

So Ordered.

Dated: October 23, 1992
Schenectady, New York

s/David A. Solomon
DAVID A. SOLOMON
Administrative Officer

ATTACHMENTS

Attachment I: Affidavit of the Respondent, 9/10/92

Attachment II: Petitioner's Affidavit Opposing Respondent's Request to Remove Dr. Myers from the Hearing Committee, 10/2/92

Attachment III: Three Letters:
Respondent to Administrative Officer, 9/17/92 Administrative Officer to Petitioner, 9/23/92 Petitioner to Administrative Officer, 10/2/92

Attachment IV: Operating Certificate: Crouse-Irving Memorial Hospital

Attachment V: Stenographic Minutes, 8/28/92, S.M. 13-20

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

AFFIDAVIT

STATE OF NEW YORK)
)
COUNTY OF ALBANY) ss:

THOMAS F. GLEASON, being duly sworn, deposes and says:

1. Your deponent is a member of the law firm of Gleason, Dunn, Walsh and O'Shea, counsel to the Respondent Gerald Moss, in the above captioned matter, and as such is fully familiar with the facts and circumstances hereinafter setforth.

2. Your deponent has been advised that Joseph K. Myers, Jr., M.D., a Hearing Officer in the above captioned matter, has knowledge of Petitioner's expert witness, Richard D. Eberle, M.D., and that both doctors had previously worked at the same hospital.

3. Upon information and belief, Dr. Myers' knowledge of Petitioner's expert presents a likely impact on the weight given to said expert's testimony.

4. Upon information and belief, we will not be able to cross-examine on the nature of said influence, not being aware of the underlying circumstances; not is it possible for the underlying circumstances to be set forth in full on the record.

5. Respondent respectfully requests that Dr. Myers be replaced by a Hearing Officer who does not know and who has no prior knowledge of Petitioner's expert.

s/Thomas F. Gleason
THOMAS F. GLEASON

Sworn to before me this
10th day of September, 1992.
Anne Ascenzi
Notary Public

ANNE ASCENZI
Notary Public, State of New York
Qualified in Albany County
Reg. No. 4777770
Commission Expires 6/30/94

STATE OF NEW YORK : DEPARTMENT OF HEALTH
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

PETITIONER'S AFFIDAVIT OPPOSING RESPONDENT'S REQUEST TO REMOVE DR. MYERS FROM THE HEARING COMMITTEE

STATE OF NEW YORK)
COUNTY OF ALBANY)

Kevin P. Donovan, being duly sworn, deposes and says that:

1. I am an Assistant Counsel for the New York State Department of Health and am representing Petitioner in the above captioned matter; as such I am fully familiar with the facts and circumstances hereinafter set forth.

2. Respondent has filed an affidavit requesting that Dr. Myers be removed from the hearing committee in this case because he has previously met Dr. Eberle, petitioner's expert witness.

3. Regulations for the New York State Department of Health provide for disqualification of a hearing officer or committee member for bias (10 NYCRR 51.17).

4. There is no evidence that Dr. Myer's view of the case will be affected by his having known Dr. Eberle. Respondent raised this issue orally at the hearing held on August 28, 1992. At that time, Dr. Myers stated that he sees Dr. Eberle perhaps once every two to three weeks passing in the hall of the hospital, they have no financial dealings, do not share practices, do not send patients back and forth. (Tr. 13-14)[1]. Dr. Myers does not have a social relationship with Dr. Eberle. (Tr. 18). Dr. Myers stated that his acquaintanceship with Dr. Eberle would not prejudice his ability to make a fair judgment in the case. (Tr. 14). Dr. Myers stated that he has no intimate knowledge of what Dr. Eberle's practice was and doesn't know whether he was a good or a bad surgeon. (Tr. 15) He also stated that there was no question in his mind but that his view of Dr. Eberle's evaluation of the cases remains to be determined (Tr. 15). Dr. Myers also stated that he can't pass judgment on Dr. Eberle's testimony because he hadn't heard it and he doesn't think he has any preconceived notions about whether Dr. Eberle is more reliable than an expert witness Respondent may produce. (Tr. 16)

6. Respondent has not met the standard set forth in 10 NYCRR 51.17, which requires a showing of:

> . . . a substantial likelihood that the case will be affected by a persons prior acquaintance with the parties, witnesses, representatives, or other participants in the hearing, ... The appearance of impropriety shall not constitute bias and shall not be grounds for disqualification. Hearing officers and committee members are presumed to be free from bias.

---

[1]Tr. indicates reference to the transcript of August 28, 1992 in this matter

7. Respondent alleges that Dr. Myers' knowledge of Petitioner's expert presents a *likely* impact on the weight he gives the expert's testimony. Even if true, Respondent's claim of *likely* impact does not meet the standard set forth in 10 NYCRR 51.17(a) that there be a *"substantial likelihood"* that the outcome of the case will be affected . . ." (emphasis added).

8. However, not only has the "substantial likelihood" test not been met, Respondent has presented *no* evidence that Dr. Myers' knowledge of Dr. Eberle will have any impact on Dr. Myers' evaluation of Dr. Eberle's testimony. Dr. Myers specifically denied that he had any preconceived notions about the reliability of Dr. Eberle's testimony (Tr. 17).

9. Respondent claims that he is unable to cross-examine anyone on the nature of the influence [presumably of the facts that Dr. Myers had previously met Dr. Eberle] because he is not aware of the underlying circumstances. As this case is now in hearing, Respondent may question Dr. Myers further by examining him on the next hearing date or by presenting any other evidence on this issue.

10. The State Administrative Procedure Act (SAPA) requires that once an affidavit has been filed concerning bias or disqualification, the agency shall determine the matter as part of the record of the case (SAPA §303). As Respondent has filed an affidavit, Respondent should present any evidence he wishes for

the record to support his claim that bias exists. At this time there is no evidence in the record to support a request to remove D. Myers for bias.

s/Kevin P. Donovan
KEVIN P. DONOVAN
Assistant Counsel

Sworn to and subscribed
before me this 2nd
day of October, 1992

s/Peter D. Van Buren
NOTARY PUBLIC

PETER D. VAN BUREN
NOTARY PUBLIC, State of New York
Qualified in Albany County
Commission Expires July 15, 1993
#4984109

GLEASON, DUNN, WALSH & OSHEA
ATTORNEYS
11 NORTH PEARL STREET
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(518) 432-7511
FAX: (518) 432-5221

September 17, 1992

David A. Solomon, Esq
2366 Algonquin Road
Schenectady, New York 12309

RE: Gerald Moss, M.D.
Our File No. 92-234

Dear Mr. Solomon:

In reference to the above, enclosed is my original Affidavit in Opposition to the use of Richard D. Eberle, M.D. as an expert witness.

Very truly yours,

GLEASON, DUNN, WALSH & O'SHEA

By: s/Thomas F. Gleason
THOMAS F. GLEASON

TFG/aa
Enc. as stated
cc: Kevin Donovan, Esq.
Gerald Moss, M.D.

David A. Solomon
ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309

September 23, 1992

Kevin Donovan, Esq.
Assistant Counsel
Office of the Counsel
NYS Department of Health
Corning Tower-Empire State Plaza
Albany, NY 12237

RE: In the Matter of
GERALD MOSS, M.D.

Dear Mr. Donovan:

A covering letter dated September 17, 1992, and an affidavit dated September 10, 1992, the former described as enclosing an Affidavit in Opposition to the use of Richard D. Eberle, M.D. as an expert witness in the subject matter, and the latter requesting the replacement of Dr. Myers as chair of the Hearing Committee by a hearing officer who does not know and has no prior knowledge of Dr. Eberle, was received by this office on September 19, 1992. Mr. Gleason stated a copy was sent to you.

Any submissions you may have in the subject matter are requested no later than October 5, 1992, to permit determination of the matter expeditioously.

Sincerely,

DAS/aw
Pcs.: T.F. Gleason, Esq.
T. Butler, Esq.

s/David A. Solomon
DAVID A. SOLOMON
Administrative Officer

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower
The Governor Nelson A. Rockefeller Empire State Plaza
Albany, New York 12237

October 2, 1992

David A. Solomon, Esq.
2366 Algonquin Road
Schenectady, New York 12309

RE: Gerald Moss, M.D.

Dear Judge Solomon:

In response to your letter dated September 23, 1992, enclosed is an affidavit opposing Respondent's request that Dr. Myers be replaced as a member of the hearing committee. Respondent's cover letter referred to a motion to replace Dr. Eberle as petitioner's expert witness, but as he has not filed an affidavit nor offered any proof as to why our expert should not testify, I will assume the reference to Dr. Eberle was a misstatement. Therefore I will not address that issue. Should Respondent make a motion or file an affidavit concerning Dr. Eberle that issue will addressed at that time.

Sincerely,

s/Kevin P. Donovan
Kevin P. Donovan
Assistant Counsel
Division of Legal Affairs

KPD:ctt

Enclosure

cc: Thomas F. Gleason, Esq.

GLEASON, DUNN, WALSH & O'SHEA
ATTORNEYS
11 NORTH PEARL STREET
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FAX: (518) 432-5221

October 22, 1992

David A. Solomon, Esq.
2366 Algonquin Road
Schenectady, New York 12309

RE: Gerald Moss, M.D.
Our File No. 92-234

Dear Judge Solomon:

Enclosed please find Supplemental Affidavit In Support Of Respndent's Request That Dr. Myers Be Removed From The Hearing Committee.

Very truly yours,

GLEASON, DUNN, WALSH & O'SHEA

By: s/James E. Dering
JAMES E. DERING

JED/aa
Enc. as stated
cc: Kevin P. Donovan, Esq.
Assistant Counsel, Division of Legal Affairs
State of New York, Department of Health

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

SUPPLEMENTAL AFFIDAVIT IN SUPPORT OF RESPONDENT'S REQUEST THAT DR. MYERS BE REMOVED FROM THE HEARING COMMITTEE

STATE OF NEW YORK)
)
COUNTY OF ALBANY) ss:

JAMES E. DERING, being duly sworn, deposes and says:

1. Your deponent is associated with the law firm of Gleason, Dunn, Walsh & O'Shea, counsel to the Respondent, Gerald Moss, M.D., in the above captioned matter, and as such is fully familiar with the facts and circumstances herein set forth.

2. This affidavit is in response to Petitioner's Affidavit Opposing Respondent's Request to Remove Dr. Myers From The Hearing Committee.

3. Your deponent has been advised that Joseph K. Myers, Jr., M.D., a Hearing Officer in the above captioned matter, has knowledge of Petitioner's expert witness, Richard D. Eberle, M.D.

4. Dr. Myers is acquainted with Dr. Eberle and is a member of the same medical staff as that of Dr. Eberle (TR. 13)[1].

5. Furthermore, Dr. Myers also serves on a committee on which Petitioner's expert, Dr. Eberle, also serves (TR. 19).

6. Based on Dr. Myers' contact with Petitioner's expert, Dr. Eberle, outside the scope of the above-captioned proceeding, Dr. Myers has the predisposition that Dr. Eberle is a competent physician (TR. 18).

7. Dr. Myers' predisposition did not evolve as a result of evidence which was put forth in the above-captioned hearing, therefore, the entirety of the circumstances which account for Dr. Myers' predisposition are unknown to Respondent and his counsel.

8. While Dr. Myers states that his acquaintanceship with Dr. Eberle would not prejudice his ability to make a fair judgment on the case (TR. 14), upon information and belief, Respondent's counsel will not be able to cross-examine on the nature of the influence of such acquaintanceship, nor in any other way determine its full extent, as it is impossible for the underlying circumstances to be set forth in full on the record; therefore, a "substantial likelihood" exits that the outcome of the case will be affected.

---

[1]TR. indicates reference to the Tanscript of August 28, 1992, in this matter.

9. Dr. Myers also stated, "I can't pass judgment on [Dr. Eberle's] testimony because I haven't heard it and I don't think that I'm going into this with any preconceived notions about whether he's more reliable than whatever your expert witness is, (TR. 17)"; however, the preconceived notion that Petitioner's expert, Dr. Eberle, is reliable, opposed to Respondent's expert, who, upon information and belief, Dr. Myers has not met and has no preconceived opinion of, upon information and belief, presents a "substantial likelihood" that the outcome of the case will be affected.

10. Respondent respectfully requests that Dr. Myers be replaced by a Hearing Officer who does not know and who has no prior knowledge of Petitioner's expert.

s/James E. Dering
JAMES E. DERING

Sworn to before me this
22nd day of October, 1992
s/Anne Ascenzi
Notary Public

Anne Ascenzi
Notary Public of State of New York
Qualified in Albany County
Lic. No. 4777770
Commission Expires 6/30/94

David A. Solomon

ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309

Telephone 518-372-8688

October 26, 1992

Kevin Donovan, Esq.
Assistant Counsel
NYS Department of Health
Office of Professional Medical Conduct
Corning Tower-ESPlaza
Albany, NY 12237

Dear Mr. Donovan:

RE: In the Matter of
Gerald Moss, M.D.

The Supplemental Affidavit in Support of Respondent's Request that Dr. Myers Be Removed from the Hearing Committee was received on October 24, 1992. It crossed in the mail with the Administrative Officer's Ruling on Bias Request.

It is requested that you be prepared to respond to the Supplemental Affidavit at the hearing date scheduled on October 29, 1992.

Sincerely,

s/David A. Solomon
DAVID A. SOLOMON
Administrative Officer

DAS/aw
p.: Thomas F. Gleason, Esq.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

PETITIONER'S AFFIDAVIT OPPOSING RESPONDENT'S SUPPLEMENTAL AFFIDAVIT TO REMOVE DR. MYERS FROM THE HEARING COMMITTEE

STATE OF NEW YORK)
COUNTY OF ALBANY)

Kevin P. Donovan, being duly sworn, deposes and says that:

1. I am an Assistant Counsel for the New York State Department of Health and am representing Petitioner in the above captioned matter; as such I am fully familiar with the facts and circumstances hereinafter set forth.

2. Respondent filed an affidavit dated September 10, 1992, requesting the removal of Dr. Myers from the hearing committee, which was responded to by my affidavit dated October 2, 1992.

3. Respondent has now filed a Supplemental Affidavit dated October 22, 1992, on the same matter.

4. Respondent's Supplemental Affidavit refers only to factual information contained in the transcript of the August 28, 1992 proceeding. The Supplemental Affidavit contains no factual information which was not available at the time Respondent initially made an oral motion to remove Dr. Myers from the hearing committee; at that time the motion was denied. (TR. 13, 223)[1]

5. Respondent's Supplemental Affidavit refers only to evidence that was available to Respondent at the time he filed his initial affidavit dated September 10, 1992 on this matter; all of this evidence was available for the Administrative Officer prior to his ruling dated October 23, 1992 denying Respondent's request to remove Dr. Myers from the hearing committee.

6. In paragraph 8 of the Supplemental Affidavit Respondent essentially states that he has no proof of bias by Dr. Myers: "Respondent's counsel will not be able to cross-examine on the nature of the influence of such acquaintanceship, nor in any other way determine its full extent, as it is impossible for the underlying circumstances to be set forth in full on the record."

7. Permitting a member of a hearing committee to be removed based on an allegation that a Respondent has a suspicion of bias that cannot be proved has no basis in law. (See State Administrative Procedure Act Section 303 and 10 NYCRR 51.17)

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[1] Tr. refers to pages of the transcript of the proceedings on August 28, 1992.

8. Respondent's statement in paragraph 9 of his Supplemental Affidavit, that Dr. Myers may view Dr. Eberle as more reliable than Respondent's expert, was directly contradicted by Dr. Myers testimony that he had no preconceived notions about whether Dr. Eberle would be more reliable than Respondent's expert. (Tr. 17).

9. Respondent's conclusory allegation in paragraph 8 of his Supplemental Affidavit that a "substantial likelihood" exits that the outcome will be affected is not supported by any facts and therefore does not provide a proper legal basis for granting Respondent's motion.

10. *Webster's Ninth New Collegiate Dictionary* (1985) defines "substantial" as "not imaginary or illusory; considerable in quantity: significantly large; being largely but not wholly that which is specified." Petitioner suggests that Respondent's concerns about Dr. Myers impartiality are not supported by any facts, and certainly are not "considerable in quantity or sufficiently large."

11. No evidence presented demonstrates any likelihood of bias, much less a "substantial likelihood" of bias.

Wherefore, because Respondent has presented no new evidence of bias and/or because Respodnent has yet to produce evidence of a substantial likelihood of bias by Dr. Myers, Respondent's motion should be denied.

s/Kevin P. Donovan
KEVIN P. DONOVAN

Sworn to and subscribed before me
this 28th day of October, 1992.
s/Peter D. Van Buren
NOTARY PUBLIC

Peter D. Van Buren
Notary Public, State of New York
Qualified in Albany County
Commission expires July 15, 1993
#4984109

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.,

PETITIONER'S MOTION TO INSTRUCT THE HEARING COMMITTEE NOT TO CONSIDER PAGES 74 THROUGH 78 OF RESPONDENT'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW OR ALTERNATIVELY TO PRESENT PETITIONER'S BRIEF IN OPPOSITION TO RESPONDENT'S MOTION TO THE HEARING COMMITTEE

As already conveyed in telephonic conference of counsel for Petitioner and Respondent with Judge Solomon on February 9, 1993, Petitioner objects to pages 74-78 of Respondent's Proposed Findings of Fact (Respondent's Brief) being considered by the Hearing Committee. These pages are the equivalent of a legal motion to dismiss charges due to a delay and lack of due process and as such, are matters to be determined by the Administrative Law Judge, not by the Hearing Committee. Furthermore, consideration of Respondent's motion to dismiss by members of the Hearing Committee may inappropriately affect their determination of the medical issues in the case to the prejudice of Petitioner.

Accordingly, Petitioner requests that the Administrative Law Judge instruct the Hearing Committee not to consider pages 74-78 of Respondent's brief in reaching their decisions concerning this case.

Alternatively, if the Administrative Law Judge decides that the arguments of Respondent contained on pages 74-78 do constitute matter which should be presented to the Hearing Committee, Petitioner requests that the brief appended hereto, entitled "Petitioner's Opposition to Respondent's Motion to Dismiss" be distributed to the Hearing Committee. This is appropriate because Petitioner reasonably did not expect that these legal issues would be raised in Respondent's Brief to the Hearing Committee. Respondent had made and the Administrative Law Judge has ruled on Respondent's oral motions at various points throughout the hearing. The Committee is now

being presented solely with Respondent's view of the law and the facts.

Wherefore, Petitioner requests that the Hearing Committee be instructed to disregard pages 74-78 of the Respondent's Brief or alternatively that the Hearing Committee be given a copy of Petitioner's Memorandum in Opposition submitted herewith.

Respectfully submitted,

s/Kevin P. Donovan
KEVIN P. DONOVAN
Assistant Counsel

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD MOSS, M.D.

PETITIONER'S MEMORANDUM IN OPPOSITION TO RESPONDENT'S MOTION TO DISMISS CHARGES

I. INTRODUCTION

Petitioner hereby opposes Respondent's Motion to Dismiss Charges as stated in pages 74-82 of "Respondent's Proposed Findings of Fact and Conclusions of Law" (Respondent's Brief). Respondent's arguments are addressed serially below in the order in which they are raised in his Brief.

II. RESPONDENT'S MOTION TO DISMISS MUST BE REJECTED BECAUSE HE HAS NOT PROVED THE LEGAL REQUIREMENTS OF UNREASONABLE DELAY.

Health Department regulations adapted pursuant to the State Administrative Procedure Act (SAPA) set forth the standards by which a claim of unreasonable delay shall be treated. The applicable regulation states that a claim of unreasonable delay is an affirmative defense and that the burden of going forward on the issue is on the claimant (See 10 NYCRR 51.11 (10).) In this case, Respondent has not complied with §51.5 in making a written affirmative defense before the first day of hearing alleging unreasonable delay, therefore his claim should be dismissed.

Assuming *arguendo,* however, that Respondent's oral claims at hearing of unreasonable delay could be seen as meeting the affirmative defense requirement, Respondent still does not meet the standards set forth in the applicable regulation. As the regulation establishes, if the time between the notice of hearing to the first day of hearing "...is one year less, the claim of unreasonable delay *shall* be denied." (10 NYCRR 51.11 (10) (i), (ii). In this case, Respondent was served on August 7, 1992, and the first day of hearing was August 28, 1992, only 21 days later (Exh. 1 and see transcript of August 28, 1992). Accordingly, Respondent's claim of unreasonable delay must be denied.

As the above-mentioned regulation was adopted after the cases cited by Respondent, his reliance on those cases is misplaced (See *Cortlandt Home v. Axelrod,* 66 NY2d 169 (1985). In any event, Respondent's claim that *Cortlandt* stands for the proposition that delay is measured from the date of misconduct to the date of hearing is in error. As stated by New York's highest court in *Cortlandt,* SAPA Section 301(1) "requires an agency to commence a hearing within a reasonable time of the date of the commencement of the adjudicatory

proceeding *Cortlandt* at 179. The relevant inquiry, when considering the reasonableness of the administrative delay in question, focuses on the period *between the date the hearing was requested and the date the hearing was conducted or scheduled. Cortlandt* at 179. As a matter of law, the 21 days between service of the Notice of Hearing and the first date of hearing cannot be seen as unreasonable.

Respondent's contentions that delay between the occurrence of the first misconduct (April 1983) until the first day of hearing (August 1992) has severely prejudiced Respondent is in reality a request to use the defenses of laches, estoppel or delay. All of these defenses have been rejected by New York's courts (*See Rojas v. Sobol* 167 AD2d 707, 708 (3rd Dept. 1990).

The two other cases cited by Respondent, *Avon v. State Division of Human Rights,* 138 Misc. 2d 466 (Supreme Court New York County 1988) and *State Division of Human Rights v. Board of Education,* 53 AD2d 1043 (4th Dept. 1970) are inapplicable to this case. First, they are based on are entirely different statutory and regulatory procedure than set forth in 10 NYCRR 51.11 (10). Second, there has been no proof, as there was in *Avon,* that important witnesses and documents could not be located and that the memories of the particular witnesses in that case could not be relied on 14 years after the facts had occurred. (*Avon* at 471)

In this case, Respondent did not show that any witnesses or any significant documents were unavailable and has not shown that memories could not be relied upon for material issues. As testified to by Respondent, he was involved in litigation concerning patients A, B, and C, the three oldest cases, by at least 1986. Respondent actually had trials in the matters of both patients A and C. Despite the fact that transcripts of his trials with both patients A and C would be available, Respondent has

not shown any substantial difference in the testimony concerning patients A or C at trial as opposed to that presented in this hearing.

Concerning missing documents, Respondent refers to the absence of prescription records for patients C and lack of office records regarding patient D. [Respondent refers to the prescription records for patient B being unavailable, however, I recall that the stipulation between the parties was that it was the prescription records for patient C that were unavailable, and therefore assume that Respondent meant to refer to Patient C.] Concerning the lack of patient C's prescription records, there is no prejudice as Respondent offered uncontradicted and unchallenged testimony that he wrote a prescription to the patient for 20 pills (Tr. 316, 1165) (See Respondent's brief at page 48).

Concerning the "office records" unavailable concerning patient D, Respondent at hearing identified the only record missing as the combined document of telephone log/calendar (Tr. (951). Respondent's claim that the missing calendar was necessary to demonstrate that follow-up appointments had been made with the patient should be disregarded. There was no allegation that Respondent failed to follow-up with the patient post-discharge. Further, there already is documentary evidence in the hospital record discharge plan which states that the patient is to be seen in Respondent's office two days post-discharge (Exh. 14 at 4).

Finally, to set to rest Respondent's assertions that the *Avon* and *State Division of Human Rights* cases stand for the proposition that cases should be dismissed as a matter of law for delay, the *Cortlandt* opinion states that *even a 10 year delay,* standing alone, does not serve as a basis for judicial intervention. (*Cortlandt* at 177-178).

RESPONDENT'S OTHER DUE PROCESS ARGUMENTS SHOULD BE REJECTED

The involvement of Drs. Guest and Bernard with Respondent's case was not improper. Respondent asserts that he was entitled to have only individuals who had no knowledge of him involved in his case. This position has no foundation in either statute or case law. It cannot be seen as a condition of due process that an investigator for the State can never be involved in an investigation of a person with whom they are familiar. This would disable the ability of the State to perform its functions. As an example, would a narcotics officer who has familiarity with a suspected drug dealer be prohibited from investigating that suspected drug dealer? The answer is clearly no. Respondent's attempt to convert every aspect of an investigation by the Office of Professional Medical Conduct into of due process hearing cannot be permitted. Clearly, as shown by the almost 2000 page transcript, Respondent's due process rights were met in the 10 days of hearing.

Interestingly, while it is asserted by Respondent that Dr. Guest had a problem with Dr. Moss's treatment of one patient, Respondent conveniently ignores that Dr. Guest reported having excellent experience with Dr. Moss on two other patients.

Furthermore, Respondent refers to Dr. Barnard having "crossed swords" with Dr. Moss in the past. Respondent did not, however, call Dr. Bernard to testify on this issue nor did he testify that he and Dr. Bernard had any disagreements.

Respondent once again argues that he was entitled to have a Hearing Committee whose members did not include anyone who knew the expert witness produced by Petitioner, referring to Dr. Myers. As Respondent has not shown that Dr. Myers had the legal bias required under 10 NYCRR 51.17, this request must be denied. Respondent attempts to demonstrate "bias" by Dr. Myers should be rejected. Respondent complains that Dr. Myers

prevented him from explaining an answer (Respondent's Brief at 78, 82) Dr. Myers was properly performing the function of Chair of the Committee in directing Respondent to answer a "yes or no" question with a "yes or no" answer (Tr. 1135). In any event, Respondent had an opportunity to explain his answer on redirect if he so wished, and did not (Tr. 1149).

Respondent refers to questioning of Dr. Myers about one patient's condition as indicating bias (Respondent's brief at 82). As one of the functions of Hearing Committee members in proceedings under Public Law Section 230 is to ask questions of witnesses, Petitioner cannot divine how this indicates anything other than performance of the duties imposed upon him by law.

WHEREFORE, Petitioner requests that Respondent's Motion to Dismiss be denied.

Respectfully submitted,

s/Kevin P. Donovan
KEVIN P. DONOVAN
Assistant Counsel

David A. Solomon

ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309

TELEPHONE 518-372-8688

February 15, 1993

Thomas F. Gleason, Esq.
Gleason, Dunn, Walsh & O'Shea
11 North Pearl Street
Albany, NY 12207

Kevin P. Donovan, Esq.
Assistant Counsel
Office of the Counsel
NYS Department of Health
Corning Tower-ESPlaza
Albany, NY 12237

RE: Matter of G. Moss, M.D.
Affidavit of Respondent's Expert

Counselors:

On February 2, 1993 Mr. Gleason requested that an Affidavit dated February 1, 1993 prepared by his medical expert witness on behalf of Dr. Moss be included in the record only. The witness, Dr. Saltzstein, was "...not permitted to testify as to the overview of all five cases. This is offered to allow the record to show the matters to which he was prepared to testify."

On February 8, 1993 Mr. Donovan submitted a letter in opposition to inclusion of the Affidavit in the record. His objections include that the Affidavit is a "...one-sided summary of the testimony he already gave at the hearing," that it addresses penalty in which the expert was not competent to provide an expert opinion and which is expressly in the purview of the Hearing Committee, and that it contains predjudicial statements that are within the sole province of the Committee. Examples of all three were provided.

The Administrative Officer notes:

1. The Affidavit is a selective distillation of the entire testimony of Dr. Saltzstein and does not provide even an outline of the entire record.

2. Paragraphs 2, 3 and 11 of the Affidavit addresses the question of penalty should any of the charges be affirmed. The incompetence of Dr. Saltzstein to make a recommendation here would have been recognized by him if he had understood that he had no opportunity to test the credibility of witnesses. Further, Public Health Law Section 230-a places the responsibility on the Hearing Committee to make the initial decision within the limits of the statute.

3. The affidavit contains predjudicial statements relating to the charges and other witnesses. Paragraph 4 sets forth that some of the charges are ludicrous; paragraph 9 characterizes some of the witnesses.

4. The medical expert did testify on Respondent's expertise and F.A.C.S. presentation. His testimony was given on Patients A, B and C at the hearing. A question of subsequent trauma of Patient B is revisited. For Patient D, the expert restates his

opinion that hospital discharge was not improper despite his support for performance of a diagnostic procedure prior to discharge. In short, the body of his testimony at the hearing is referred to. It is the testimony itself, however, along with the entire remaining record, that is the basis of the Committee's decision. The expert's conclusion on Patient D and his conclusion that some record keeping charges are valid do not belong in an affidavit, but in his testimony where they were explored by both attorneys and the Committee.

5. And again, the expert wishes to comment generally on what he characterizes as a low complication rate for a series of the Respondent's selected cases that are not subjects of the hearing, when his judgement is palpably based on hearsay. Two of the cases were included in the charges and are commented on in the record.

6. The Petitioner's position that it is impossible for him or the Committee to cross examine an affidavit cannot be refuted.

For the reasons set forth, the Administrative Officer has determined that the affidavit of the Respondent's expert witness could very well predjudice any review of the matter; his testimony deserves to stand on the record. The request of the Respondent to include the affidavit in the record is denied. The affidavit and the Petitioner's letter are returned in their copies of this decision.

Sincerely,

s/David A. Solomon
DAVID A. SOLOMON
Administrative Officer

DAS/aw
encls. as noted

Pages 15-28 of Gerald Moss' Reply Brief in the New York State Supreme Court, Appellate Division.

difficulty encountered by Dr. Bernard in his concerted effort to bring about the professional demise of Petitioner.

a) *Petitioner Has Shown Clear Prejudice Due to Delay.*

Respondents' argument that Petitioner was not prejudiced by the substantial delay, on this record, is nothing short of ridiculous in light of Respondents' heavy emphasis on the alleged patient complaints supposedly reported to Petitioner at the time of the care in issue.

Respondents effectively concede that the procedures utilized below pursuant to 10 NYCRR 51.11 (d) (10) do not provide any opportunity whatsoever to show that the Petitioner was grossly prejudiced by the delay in the proceedings. (Respondents' brief p. 28) Instead, Respondents make the argument that Petitioner now is provided with the opportunity to prove the prejudice that resulted in the delay. In response to such arguments, Respondents state that all that Petitioner must show is "actual prejudice", but argues that there is no way to demonstrate prejudice on the instant record. This conclusion is completely contrary to the record. However, it is in effect a concession that where, as here, prejudice is clearly shown, reversal is warranted.

While Respondents state that prejudice cannot be shown in view of the six year delay between the last of the incidents and formal service of charges, in comparing this case to *McBarnette v. Sobol,* (83 NY2d 333), Respondents state that "6 to 9 years" cannot be compared with "the 15 to 20 year delay in *McBarnette".* (Respondents' brief p. 37). If that is the standard Respondents argue for review under *McBarnette,* it is clear that they have misread the decision. *McBarnette* stands for the proposition that prejudice can result due to the unavailability of

witness complaints, and in the context of that case, as in this case, the prejudice clearly was exacerbated by lengthy delay.

Respondents' assertion that Petitioner did not specify evidence which has been lost (Respondents' brief p. 30), is totally misleading.

i) *Patient A*

For example, Respondents argue that the unavailability of Dr. Benitez, who died, could not hinder the Petitioner with the development of the facts regarding Patient A. Respondents argue that "Dr. Benitez performed the autopsy on Patient A and could only testify as to whether this Patient was, at the time of death, suffering from peritonitis." (Respondents' brief, p. 31). Respondents further argue that because the charges against Petitioner regarding his treatment of Patient A "focus on whether he adequately responded to her post-discharge symptoms, and do not allege any misdiagnosis for peritonitis, such testimony by Dr. Benitez would not have any impact on the final determinations of the Hearing Committee" (Respondents' Brief p. 31).

Again, the Respondents completely miss the point. As they themselves note in their version of the facts regarding Patient A "in the days immediately following Patient A's discharge, Patient A's family made repeated phone calls to Petitioner expressing their concern over her severe pain and worsening condition" (Respondents' brief p. 5). Respondents further concluded that:

> "during the visit, Patient A's stepdaughter told Petitioner that Patient A was in a lot of pain, that she had been vomiting, and that she was in a lot of distress (A.500). According to Dr. Eberle, these symptoms should have indicated to Petitioner that there was 'something adverse

> going on in the abdomen, which required examination and care'."

(Respondents' brief p. 5).

Therefore, the Respondents heavily relied on the credibility issues regarding Patient A's medical condition immediately prior to her death. What objective medical proof substantiated the claimed complaints of progressing severe pain when the patient was at home? The autopsy report in this case (R.88; SA. 1) states that the chief diagnosis of the doctor who performed it, the deceased Dr. Benitez, was that Patient A suffered from "peritonitis, acute".

This in turn raised the issue of whether the tissues in a Patient A's abdomen that were examined by Dr. Benitez at the time of the autopsy gave rise to evidence of an on-going peritonitis condition, which would be consistent with the alleged patient complaints, or whether there was evidence that peritonitis was not present, and the pain reported by Patient A was the pain expected with the extremely lengthy surgical incision.

In this respect, Dr. Stein testified that peritonitis, had it existed prior to death, would clearly have been shown on the tissue samples. The samples would have shown an inflammatory response, had the leakage from Patient A's intestine (which was found at the time of autopsy) occurred *prior* to death. Medical proof in the record, particularly the testimony of Dr. Stein regarding his examination of pathology slides, shows that the tissue samples from the Patient's abdomen did not reveal any evidence of pre-death peritonitis. (R.2147-2148; A. 0580-0581).

This is totally inconsistent with the conclusion that the Patient did have the alleged severe medical condition prior to her death (as opposed to the death of this 85 year old woman being from other unrelated clauses). Patient A's family (mislead by the erroneous autopsy report) clearly believed that Patient A's

discomfort and death were the result of peritonitis, and that Petitioner was responsible for Patient A's death. This related to their credibility at the point in time when they gave testimony against Petitioner, regarding the complaints supposedly communicated to Petitioner. Under these circumstances, Petitioner could not call Dr. Benitez' to establish that his autopsy findings actually should have ruled out peritonitis, and with it the claimed pre-death reports of unusual pain.

The 10 year delay also clearly impacted on testimony of Patient A's family members, who previously had testified in an unsuccessful malpractice case against Petitioner, and gave completely inconsistent answers with regard to crucial aspects of their factual account. A comparison of the testimony of Patient A's daughter-in-law before and after being confronted with this inconsistent testimony, is instructive:

* * *

Q. Were you there at a time when—did you happen to overhear the conversation that your husband had with Dr. Moss?

A. No, I didn't overhear it, *but I was in the other room.*

Q. Okay, You became aware that during that phone conversation with Dr. Moss an appointment was set for your mother-in-law for the next day?

A. Yes.

* * *

Q. Let's go to the next day, Tuesday, the 12th.

A. Okay.

Q. What did you do that day during the morning?

A. I worked during the day and *I went there after work.*

Q. After you arrived at your mother-in-law's after work, where you aware that anyone called Dr. Moss?

A. Yes. My husband called at 6 o'clock. *He called while I was there.*

Q. While you were physically present?

A. *I was there,* but I was in another part of the house, I was in another room, but he called, yes.

* * *

A. We had to help her in and out of the car, we had to help her to walk into the Doctor's office, and from then on when I saw her she was in bed *because I was there everyday.* She was in bed all of the time.

* * *

(R.1471, A..0498; R.1475, A. 0502; R.1486-1487, A0513-0514 [emphasis added]).

Patient A's daughter-in-law was then recalled as a witness, and was asked about the inconsistent testimony she had given in the unsuccessful malpractice suit against Petitioner:

* * *

Q. ". . . Answer: Yes. Question: Did you visit her prior to that office visit with Dr. Moss? Answer: Yes. Question: At her home? Answer: *No, I don't think I did, I don't remember that I did.* Question: So you didn't make any observations prior to that office visit of Patient A? Answer: No. Question: All right. and once you brought her back from the office to her home and you left, were you at the home at all at any time prior to Patient A's death? Answer: Just the morning they took her out in the ambulance, that's the only time. Question: How about before that at all? Answer: *No.*

A. I don't know why I said that, Alls [sic] I say, I just maybe misunderstood or else I was just nervous, but I was there every day.

Q. Would it be fair to state that your testimony as you recalled it on August 5, 1988 is inconsistent with the testimony you gave before the panel here?

A. Inconsistent?

Q. In the sense of describing your presence at the mother-in-law's house.

A. I don't know how to answer that. I just—as I said, I was very nervous, which I am also now—

Q. I understand.

A. —and I might have just answered wrong. I don't—you're not trying to say that I lied.

* * *

Q. So you were there every day?

A. Yes.

Q. But your recollection, at least, is different from what it was in 1988, is that—

A. I guess so.

(R.2540-2541, SA.23-24; R. 2543, SA. 25 [emphasis added]).

Thus, due to lapse of time, at the very least there clearly were failures of recollection regarding essential aspects of Patient A's circumstances prior to her death, resulting in completely inconsistent testimony, as to who was even present at the house. Also the medical condition of Patient A just subsequent to her death could not adequately be explored due to the absence of Dr. Benitez, who is deceased. These failures clearly impacted on the issues of reported patient pain, on which Respondents still place great reliance.

Under these circumstances, Respondents assertion that there was no prejudice as a result of Dr. Benitez' unavailability, or the lapse of time which ensued since Patient A's death in 1983, again is nothing short of ridiculous.

ii) *Patient B*

They were sustained findings of fact regarding alleged reports of Patient B's pain, which were not documented by Petitioner. Respondents' argue that the unavailability pain medication documentation regarding Patient B could not be relevant because ". . . none of the charges sustained by the hearing

committee in relation to Patient B involve that Patient's consumption of pain medication. . ." (Respondents' brief p.30). This is misleading, because Respondents also assert that:

> "Patient B returned to Petitioner's office the following Sunday, October 9, 1983, because he had severe back pain, was sweating heavily, was feeling generally in poor health. (RA. 15) He was in such pain that he was unable to drive himself to the appointment, and in fact, arrived at the office doubled over from pain."

(Respondents' brief p. 11).

Even in their brief to this Court, Respondents place great emphasis on the existence of patient pain, supposedly communicated to Petitioner, and which was accepted by the panel (R.3932; A. 57). Since the number of pain pills still in the original prescription was known at the time of the hearing, but the original prescribed amount was not, the stipulated unavailability of prescription records (R.2906-2907; SA. 32-33) deprived Petitioner of the ability to prove that the patient supposedly communicating great pain to Petitioner had not taken the pain relief medication in a prescription actually filled.

Also, regarding Patient B, Dr. Suozzo, who also treated the Patient, had substantial failure of recall. He stated:

* * *

By Dr. Menotti:

Q. Therefore, at the time you saw this patient, he had suffered a recent cardiopulmonary arrest, was extremely acidotic, was on a ventilator, and you would have no

way of knowing whether this patient had pain or not, would you?

A. Right.

Q. And indeed, if you didn't refer to these notes from events that happened in 1983, you would have no recollection of this whatsoever, is that correct?

A. True.

Q. Thank you.

* * *

iii) *Patient C.*

Serious loss of proof problems also were encountered regarding Patient C, who was found to have been improperly evaluated by Petitioner, again predominately due to alleged patient complaints. Patient C was a 53 year old white male who had emergency surgery for acute cholecystitis on Friday, April 13, 1984. He was discharged the following day, walking, eating, and without fever. The record confirms that Petitioner remained at the patient's side for 10 consecutive hours, 8:00 PM-6:00 AM; and that he actively delivered care during more than 12 of the patient's 32 hours of hospitalization.

Petitioner met routinely with Patient C the next day (Sunday) for an office visit, and again on Wednesday (2 & 5 days postop). Patient C was recovering unremarkably, until 6-7 days postop.

At the time, Petitioner was leaving the state and had signed out to Dr. Robert Suozzo, who covered for Petitioner on surgical cases, on Thursday night, 6 days postop. The Office of Professional Medical Conduct faulted Petitioner for not readmitting

the patient Friday morning. Patient C called Petitioner at home, within hours of Petitioner leaving the state, to report the onset of fever and right sided lung pain. Petitioner arranged for the patient to be immediately seen and x-rayed by his family physician, Dr. Gavin, who was the referring doctor. Dr. Gavin testified that he accepted responsibility for the patient's continuing care at that time. However, he could not recall all events or whether he had actually seen the patient. He stated:

* * *

Q. That on that day, you understood Dr. Moss to be leaving town, is that correct?

A. That's right.

Q. And that on that day, care of the patient was being transferred to you?

A. Yes.

Q. And it's your belief that you probably saw and spoke to the patient?

A. Yes.

Q. But you're not sure?

A. That's right, I'm not sure.

Q. And you have no recollection of noting any symptoms of the patient, is that fair to state?

A. That's fair.

* * *

(R.2415; SA. 22).

After the office visit, which Dr. Gavin could not fully recall, he stated that the patient's symptoms shifted to the abdomen and worsened overnight. Dr. Gavin had a surgeon admit him Saturday, 8 days postop. The subphrenic collection was recognized and drained 3 days after, 11 days postop. He recovered completely.

Dr. Moss' office record reflected no previous complaints. The panel again accepted patient allegations of severe and continuous postop pain, fever, hiccoughs, etc. (R. 3985; A.110) Because Dr. Gavin could not fully recall the events of the day when the patient arrived, Petitioner was prejudiced by his inability to have an independent unbiased witness describe the patient's actual condition on the last day Petitioner saw Patient C.

iv) *Patient D.*

Similarly, Respondent finds no problem due to the unavailability of the office records, which involved Patient D. The hospital records regarding Patient D establish that Petitioner was concerned regarding an infection that had persisted over a substantial period of time. However, there came a point in the exercise of medical judgment as to whether this concern could best be addressed by close home observation. The hospital chart establishes the instructions given to Patient D's mother (R.742-743; SA. 5-6). The question raised in the Statement of Charges is whether Petitioner should have discharged Patient D without first performing a rectal examination or further evaluating her condition. Whether such conduct was reasonable under the

circumstances directly related to the closeness with which the Patient was being followed subsequent to hospital discharge.

In this regard, the fact that Petitioner was following the care of Patient D, but that Patient D's family refused to return for office visits, is directly probative on the nature of the follow-up care which was being provided by the Petitioner, and concerning whether the performance of the rectal examination could reasonably have been delayed. Unfortunately, this documentation was no longer available, because the office appointment books were no longer available.

b) *Respondents' Argument on Prejudice.*

Respondents' assertion that counsel for Petitioner limited the claim of lost evidence to "an appointment calendar" is a misrepresentation of the record (Respondents' brief, p. 30). In fact, the reference shows discussion of much lost evidence, particularly Dr. Gavin's lapsed recollection, the inconsistent testimony regarding Patient A and the lost appointment books regarding Patient D (RA.174). In any event, such argument is bizarre in view of Respondents' acknowledgement that the issue of prejudice could not be decided below. (Respondents' brief, p. 28).

The Respondents' argument on delay is set forth on page 29 of their brief. Respondents' position is that Petitioner's medical license involves interests of the public, and that there is therefore no problem with bringing cases against a medical practitioner after an unreasonable delay. This is an incorrect statement of the law. While this Court did state, in *Rojas v. Sobol,* (167 AD2d 707, 708), that errant behavior of professionals is not shielded by time limitations, it is another thing entirely to state that unexplained gross delay excuses obvious indications

THE STATE OF NEW YORK
COURT OF APPEALS

In the Matter of GERALD MOSS,

Petitioner, Appellant,

against

MARK R. CHASSIN, as Commissioner of the State of New York Department of Health; STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT, and ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT,

Respondents, Respondents.

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
COUNTY OF ALBANY) SS:

ANNE ASCENZI, being duly sworn, deposes and says that she is over the age of 18 years old and that she is not a party to the within action; that on the 23rd day of December, 1994, she served the Notice of Motion For Leave to Appeal, in triplicate upon the following persons in the following manner:

Hon. G. Oliver Koppell
Attorney General of the
State of New York
ATTN: MARK G. PETERS, ESQ.
Assistant Attorney General
120 Broadway
New York, New York 10271

via regular first-class mail by depositing a true and correct copy of the same properly enclosed in a post-paid wrapper in the Official Depository maintained and exclusively controlled by the United States Post Office in Albany, New York at 11 North Pearl Street, Albany, New York, directed to said persons at said address, that being the last known address in the state designated for that purpose upon the last papers served in this action or the places where the above then resided or kept offices, according to the best information which can be conveniently obtained.

s/ Anne Ascenzi
ANNE ASCENZI

Sworn to before me this,
23rd day of December, 1994
s/ Rosalyn Schwartzberg
Notary Public

ROSALYN SCHWARTZBERG
Notary Public, State of New York
No.8878855
Qualified in Albany County
Commission Expires 11/30/96